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ABSTRACT

The hearings before the Senate Committee on Human Resources regarding the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978 are presented in full. The purpose of the bill is stated to be to establish a program for developing networks of community-based services to prevent initial and repeat pregnancies among adolescents, to provide care to pregnant adolescents, and to help adolescents become productive independent contributors to family and community life. The text of the bill is presented in full, followed by testimony and statements from a number of expert witnesses. Additional information in the form of articles, publications and letters is also included. (Author)

ADOLESCENT HEALTH, SERVICES, AND PREGNANCY PREVENTION AND CARE ACT OF 1978

HEARINGS

BEFORE THE

COMMITTEE ON HUMAN RESOURCES

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

ON

S. 2910

TO ESTABLISH A PROGRAM FOR DEVELOPING NETWORKS OF COMMUNITY-BASED SERVICES TO PREVENT INITIAL AND REPEAT PREGNANCIES AMONG ADOLESCENTS, TO PROVIDE CARE TO PREGNANT ADOLESCENTS, AND TO HELP ADOLESCENTS BECOME PRODUCTIVE INDEPENDENT CONTRIBUTORS TO FAMILY AND COMMUNITY LIFE

JUNE 14, AND JULY 12, 1978

Printed for the use of the Committee on Human Resources

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ADOLESCENT HEALTH, SERVICES, AND PREGNANCY PREVENTION AND CARE ACT OF 1978

WEDNESDAY, JUNE 14, 1978

U.S. SENATE,
COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The committee met, pursuant to notice, at 9:33 a.m., in room 4232, Dirksen Senate Office Building, Senator Harrison A. Williams, Jr. (chairman), presiding.

Present: Senators Williams, Kennedy, Cranston, Riegle, Schweiker, Chafee, Hatch, Hathaway, and Hayakawa.

OPENING STATEMENT OF SENATOR WILLIAMS

The CHAIRMAN. We will come to order. The Committee on Human Resources meets today to begin formal consideration of S. 2910 the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978. This legislation represents a determined effort by its sponsors and the Carter administration to focus national attention on the complex problems of teenage pregnancy. It is a problem of many dimensions, cutting across social and economic boundaries and occurring in every community—urban, suburban, and rural—across the country. It is a growing problem. Studies have indicated that more than 1 million young women, ages 15 to 19, become pregnant each year; approximately 600,000 of them give birth. Teenagers under the age of 15 account for an additional 30,000 births each year.

The social, moral, and economic implications of teenage pregnancy are great. But, more important, it inflicts serious consequences on the young mother and her child not only in their immediate future, but their entire lives. The young mother faces grave risks to her health in bearing and giving birth to a child, and the newborn faces greater probability of developmental disability, neurological impairment, epilepsy, mental retardation, and other serious health problems. Educational opportunities for the young expectant mother are constricted by societal attitudes and by the lack of adequate child care services. As a result, she faces a bleak future—limited employment prospects, poor chances of developing a meaningful career, and lifelong difficulties in providing financial support for herself and her child.

The complexity of the problem demands a comprehensive approach based on a national commitment to integrate health, educational, and social services in a coordinated manner. Primary pregnancy prevention efforts must be expanded to enable these young women to post-

pone childbearing until they are prepared to establish a stable homelife for their child. Education on sexuality, reproduction, contraception, the effects of early childbearing, and a range of available services are critically needed. For the pregnant teenager, compensatory assistance must be upgraded and expanded to help her give her child every opportunity for health, happiness, and a bright future.

Our hearing today will provide the committee with detailed and expert testimony on the scope of the problem, the immensity of the social and personal implications, and the extent of the unmet needs. My colleagues, Senator Kennedy and Senator Cranston, and their associates on the Subcommittee on Health and Scientific Research and the Subcommittee on Child and Human Development, have been exploring for a long time the legislative alternatives for addressing this problem. With their help, and that of the distinguished witnesses who are with us today, I believe the committee will develop the impetus for revising and strengthening this bill, S. 2910, and obtaining its passage by the Congress.

[Text of S. 2910 follows:]

95TH CONGRESS
2D SESSION

S. 2910

IN THE SENATE OF THE UNITED STATES

APRIL 13 (legislative day, FEBRUARY 6), 1978

Mr. KENNEDY (for himself, Mr. WILLIAMS, Mr. JAVITS, and Mr. HATHAWAY) introduced the following bill; which was read twice and referred to the Committee on Human Resources

A BILL

To establish a program for developing networks of community-based services to prevent initial and repeat pregnancies among adolescents, to provide care to pregnant adolescents, and to help adolescents become productive independent contributors to family and community life.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978".

FINDINGS AND PURPOSES

SEC. 2. (a) The Congress finds that—

(1) adolescents are at a high risk of unwanted pregnancy;

(2) in 1975, almost one million adolescents became pregnant and nearly six hundred thousand carried their babies to term;

(3) pregnancy and childbirth among adolescents, particularly young adolescents, often results in severe adverse health, social, and economic consequences, including: a higher percentage of pregnancy and childbirth complications; a higher incidence of low birth weight babies; a higher frequency of developmental disabilities; higher infant mortality and morbidity; a decreased likelihood of completing schooling; a greater likelihood that adolescent marriage will end in divorce; and higher risks of unemployment and welfare dependency;

(4) an adolescent who becomes pregnant once is likely to experience rapid repeat pregnancies and childbearing, with increased risks;

(5) the problems of adolescent pregnancy and parenthood are multiple and complex and are best approached through a variety of integrated and essential services;

(6) such services, including a wide array of educational and supportive services, often are not available to the adolescents who need them, or are available but

fragmented and thus of limited effectiveness in preventing pregnancies and future welfare dependency; and

(7) Federal policy therefore should encourage the development of appropriate health, educational, and social services where they are now lacking or inadequate, and the better coordination of existing services where they are available, in order to prevent unwanted early and repeat pregnancies and to help adolescents become productive independent contributors to family and community life.

(b) It is, therefore, the purpose of this Act—

(1) to establish better linkages among existing programs in order to expand and improve the availability of, and access to, needed comprehensive community services which assist in preventing unwanted initial and repeat pregnancies among adolescents, enable pregnant adolescents to obtain proper care and assist pregnant adolescents and adolescent parents to become productive independent contributors to family and community life;

(2) to expand the availability of community services that are essential to that objective; and

(3) to promote innovative, comprehensive, and integrated approaches to the delivery of such services.

TITLE I—GRANT PROGRAM

AUTHORITY TO MAKE GRANTS

SEC. 101. The Secretary of Health, Education, and Welfare (hereinafter in this Act referred to as "the Secretary") may make grants to public and nonprofit private agencies and organizations to support projects which he determines will help communities coordinate, and establish linkages among, services that will further the purposes of this Act and, where appropriate, will provide, supplement, or improve the quality of such services.

USES OF GRANTS

SEC. 102. (a) Funds provided under this Act may be used by grantees to—

(1) link services to—

(A) prevent unwanted initial and repeat pregnancies among adolescents; and

(B) assist adolescents who are pregnant or who have already had their babies to obtain proper care, prevent unwanted repeat pregnancies, and become productive and independent contributors to family and community life;

(2) identify and provide access to other services for adolescents to help prevent unwanted pregnancy and assist adolescents in becoming productive and independent contributors to family and community life;

(3) supplement services and care not adequate in the community which are essential to the prevention of adolescent pregnancy and to assist adolescents in becoming productive and independent contributors to family and community life;

(4) plan for the administration and cooperation of pregnancy prevention and pregnancy-related services for adolescents which will further the objectives of the Act;

(5) provide technical assistance to enable other communities to develop successful pregnancy prevention and pregnancy-related programs for adolescents; and

(6) provide training (but not including institutional training or training and assistance provided by consultants) to providers of services, including skills in multidisciplinary approaches to pregnancy prevention and pregnancy-related services for adolescents and in the provision of such services.

(b) For purposes of this Act, projects which link services means projects which enable the provision of a comprehensive set of services in a single setting or establish a well-coordinated network of services in a community, including outreach to adolescents, the making available of services in a convenient manner and in easily accessible locations, and

followup to assure that the adolescent is receiving appropriate assistance. The services which may be included in such projects include, but are not limited to family planning services, education at the community level concerning sexuality and the responsibilities of parenthood, health, mental health, nutrition, education, vocational, and employment counseling, prenatal and postpartum health care, residential care for pregnant adolescents, and services to enable pregnant adolescents to remain in school or to continue their education.

(c) Grantees may not establish income eligibility requirements for services paid for with funds under this Act, but grantees shall insure that priority is given to the objective of making such services available to adolescents at risk of initial or repeat pregnancies who are not able to obtain needed assistance through other means.

(d) Grantees may charge fees for services paid for with funds under this Act, but only pursuant to a fee schedule, approved by the Secretary as a part of the application described in section 104, which bases fees charged by the grantee on the income of the service recipients or parents and takes account of the difficulty adolescents face in obtaining resources to pay for services.

(e) Except as provided in this subsection, in no case may a grantee under this Act use in excess of 50 per centum

of its grant under this Act in any year to cover any part of the cost of services. The Secretary may grant a waiver of the limitation specified in the preceding sentence in accordance with criteria to be specified in regulations.

PRIORITIES, AMOUNTS, AND DURATION OF GRANTS

SEC. 103. (a) In approving applications for grants under this Act, the Secretary shall give priority to applicants who—

(1) serve an area where there is a high incidence of adolescent pregnancy;

(2) serve an area where the incidence of low-income families is high and where the availability of pregnancy-related services is low;

(3) show evidence of having the ability to bring together a wide range of needed services in comprehensive single-site projects, or to establish a well-integrated network of outreach to, and services for, adolescents at risk of initial or repeat pregnancies;

(4) will utilize, as a base, existing programs and facilities, such as neighborhood and primary health care centers, children and youth centers, maternal and infant health centers, school educational programs, mental health programs, nutrition programs, recreation programs, and other ongoing pregnancy prevention and pregnancy-related services;

(5) make use, to the maximum extent feasible, of other Federal, State, and local funds, programs, contributions, and other third-party reimbursements;

(6) can demonstrate a community commitment to the program by making available to the project non-Federal funds, personnel, and facilities; and

(7) have involved the community to be served, including public and private agencies, adolescents, and families, in the planning and implementation of the project.

(b) The amount of a grant under this Act shall be determined by the Secretary, based on factors such as the incidence of adolescent pregnancy in the geographic area to be served, and the adequacy of pregnancy prevention and pregnancy-related services in the area to be served.

(c) (1) A grantee may not receive funds under this Act for a period in excess of five years.

(2) The grant may cover not to exceed 70 per centum of the costs of a project assisted under this Act for the first and second years of the project. Subject to paragraph (3), in each year succeeding the second year of the project the amount of the Federal grant under this Act shall decrease by no less than 10 per centum of the amount of the Federal grant under this Act in the preceding year.

(3) The Secretary may waive the limitation specified

in the preceding paragraph in any year in accordance with criteria to be specified in regulations.

REQUIREMENTS FOR GRANT APPROVAL

SEC. 104. (a) An application for a grant under this Act shall be in such form and contain such information as the Secretary may require, but must include—

(1) an identification of the incidence of adolescent pregnancy and related problems;

(2) a description of the economic conditions and income levels in the geographic area to be served;

(3) a description of existing pregnancy prevention and pregnancy-related services, including where, how, by whom and to whom they are provided, and the extent to which they are coordinated in the geographic area to be served;

(4) a description of the major unmet needs for services for adolescents at risk of initial or repeat pregnancies, the number of adolescents currently served in the area, and the number of adolescents not being served in the area;

(5) a description of certain core services to be included in the project or provided by the grantee, to whom they will be provided, how they will be linked, and their source of funding, to include some, but not necessarily all, of the following:

(A) family planning services;

(B) health and mental counseling;

(C) vocational counseling;

(D) educational services, which supplement regular school programs, to help prevent adolescent pregnancy and to assist pregnant adolescents and adolescent parents to remain in school or to continue their education.

(E) primary and preventive health services including pre- and post-natal care; and

(F) nutritional services, and nutritional information and counseling;

(6) a description of how adolescents needing services other than those provided directly by the grantee will be identified and how access and appropriate referral to those services (such as medicaid; public assistance; employment services; infant, day, and drop-in care services for adolescent parents; and other city, county, and State programs related to adolescent pregnancy) will be provided;

(7) a description of any fee schedule to be used for any services provided directly by the grantee and the method by which it was derived;

(8) a description of the grantee's capacity to sustain funding as Federal funds are phased down and out;

(9) a description of all the services and activities to be linked, the results expected from the provision of such services and activities, and a description of the procedures to be used for evaluating those results;

(10) a summary of the views of public agencies, providers of services, and the general public in the geographic area to be served, of the proposed use of the grant provided under this Act and a description of procedures used to obtain those views, and, in the case of applicants who propose to coordinate services administered by a State, the written comments of the appropriate State officials responsible for such services;

(11) a description of how the services and activities funded with a grant under this Act would be coordinated with existing related programs in the geographic area to be served by the grantee;

(12) assurances that the applicant will make every reasonable effort to collect appropriate reimbursement for its costs in providing services to persons who are entitled to have payment made on their behalf for such services under any Federal or other Government program or private insurance program; and

(13) assurances that the acceptance by any individual of family planning services or family planning or population growth information (including educational

materials) provided through financial assistance under this title shall be voluntary and shall not be a prerequisite to eligibility for or receipt of any other service furnished by the applicant.

(b) Each grantee which participates in the program established by this title shall make such reports concerning its use of Federal funds as the Secretary may require. Reports shall include the impact the project has had on reducing the rate of first and repeat pregnancies among adolescents, and the effect on factors usually associated with welfare dependency.

AUTHORIZATION OF APPROPRIATIONS

SEC. 105. For the purpose of carrying out this title, there are authorized to be appropriated $60,000,000 for the fiscal year 1979, and such sums as may be necessary for the fiscal year 1980 and the fiscal year 1981.

TITLE II—IMPROVING COORDINATION OF FEDERAL AND STATE PROGRAMS

SEC. 201. (a) The Secretary shall coordinate Federal policies and programs providing services related to prevention of initial and repeat adolescent pregnancies. Among other things, the Secretary shall—

(1) require, that grantees under title I report

periodically on Federal programs or policies that interfere with the delivery and coordination of pregnancy prevention and pregnancy-related services to adolescents;

(2) provide technical assistance to assure that coordination by grantees of Federal programs at the local level will be facilitated;

(3) modify program administration, or recommend legislative modifications of programs of the Department of Health, Education, and Welfare that provide pregnancy-related services in order to facilitate their use as a base for delivery of more comprehensive pregnancy prevention and pregnancy-related services to adolescents;

(4) give funding priority, where appropriate, to grantees using single or coordinated grant applications for multiple programs; and

(5) give priority, where appropriate, to providing funding under existing Federal programs to projects providing comprehensive pregnancy prevention and pregnancy-related services.

(b) A State using funds provided under title I to improve the delivery of pregnancy prevention and pregnancy-related services throughout the State shall coordinate its

activities with programs of local grantees, if any, that are funded under title I.

(c) The Secretary may set aside, in each fiscal year, not to exceed 1 per centum of the funds appropriated under this Act for evaluation of activities under titles I and II.

The CHAIRMAN. It is most appropriate that the Secretary of HEW, Secretary Joseph Califano, will begin us on this journey, which we hope will not be a long one, to congressional action in this area of great concern.

Before we turn to Secretary Califano, Senator Cranston, who has been part of the development of this important legislation would like to be recognized.

Senator CRANSTON. Thank you very much. I would like to say just a few words at the outset, and I welcome you here, Joe, to this very significant hearing.

Teenage pregnancy is the major social and health problem affecting adolescents. I am pleased the administration is taking the initiative in trying to address this issue. There are two important objectives of any program which seeks to help these young people meet the challenges of growing up in today's society. These objectives are: First, helping these young people avoid unwanted pregnancies by improving the accessibility of voluntary family planning services in the community and, second, giving every assistance possible to the teenager who does become pregnant, to insure that she and her child will have the greatest opportunity for self-realization and happy, healthy lives.

I look forward to working with Senator Williams, Senator Kennedy, and other members of the committee in insuring that the legislation reported from the committee will address both of these objectives.

I was pleased the legislation I offered, S. 2522, passed the Senate last week. That bill authorizes sizable increases in the level of funds available for voluntary family planning services supported under title X of the Public Health Service Act, and targets much of that increase to reach the adolescent population. In addition, that bill authorizes increases in the appropriations for the information and education programs supported under title X authorities, and places special emphasis on the development by, and dissemination through, appropriate community organizations of information and materials for adolescents. This legislation rejects the administration's proposal, however, to increase family planning services for adolescents by cutting back on services for adults.

Numerous witnesses testified at our hearings on S. 2522 that adolescents choose organized family planning clinics rather than private physicians or community health clinics when they wish preventive family planning services. To some extent, the organized family planning clinic becomes the major source of health care for these adolescents, and provides critical, early prenatal care to those who become pregnant. I have also been impressed with the variety of programs that have been developed in the communities directed toward insuring that the pregnant adolescent is given the full range of social, educational, and health services that will help her through pregnancy and motherhood to achieve her own personal goals.

During these hearings, we will learn a great deal more about the extent of existing resources in communities and ways in which they can best be utilized in serving adolescent needs. I believe it is important that the legislation we develop be sufficiently flexible to enable each community to utilize the support that it provides in the most effective manner.

I have quite a few questions, but I will wait for those until later. Thank you very much.

The CHAIRMAN. The ranking member of the Subcommittee on Health, Senator Schweiker.

Senator SCHWEIKER. Thank you very much, Mr. Chairman. I want to commend the chairman for these hearings today. I think they focus on a very important problem, and I am particularly appreciative of the Secretary of HEW's approach and his interest and commitment to this problem, a problem which has been neglected for many years.

I also want to particularly commend the Kennedy Foundation for their leadership over the years in this vital area, and I am glad to see the Government and the private sector coming together with this committee to try to solve the problem, and I hope to play a very constructive and positive role in it.

Thank you very much, Mr. Chairman.

The CHAIRMAN. I am confident that you will.

Senator Riegle.

Senator RIEGLE. Thank you, Mr. Chairman, I am pleased to join you, Senator Cranston, and Senator Kennedy in cosponsoring 2910. We need to respond to the young women who become pregnant and face these profound life decisions very early in the game. I think we need an initiative of this kind, a comprehensive proposal of counseling and assistance. And so, I am pleased to cosponsor this legislation. I will be very interested to hear what the Secretary and other witnesses have to say.

The CHAIRMAN. Without further opening remarks from here, we are very happy to turn to you, Mr. Secretary, to make the initial and the opening statement on this major matter before us.

STATEMENT OF HON. JOSEPH A. CALIFANO, JR., SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. CALIFANO. Thank you, Mr. Chairman. I would like to request, Mr. Chairman, that my entire statement be made a part of the record, although I intend to read portions of it.

The CHAIRMAN. It certainly will be. You may proceed in any manner that you wish.

Mr. CALIFANO. Mr. Chairman, I am pleased to appear before this committee to testify in support of the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978. I deeply appreciate, as does President Carter, the high priority that this committee is giving to this legislation and that you, Mr. Chairman, Senator Cranston, Senator Schweiker, Senator Riegle, Senator Kennedy, and others, have given to this legislation.

Teenage pregnancy—the entry into parenthood of individuals who barely are beyond childhood themselves—is one of the most serious and complex social problems facing our Nation today. For most of us, the birth of a child is an occasion of great joy and hope, an investment in the future, a consecration of life. But for hundreds of thousands of teenagers, particularly the majority who are unmarried, the birth of a child can usher in a dismal future of unemployment, poverty, family breakdown, emotional stress, dependency on public agencies, and health problems for mother and for child.

Consider what is likely to befall the teenage mother: Eight of ten women who have become mothers by age 17 never complete high school. The annual earnings of a woman who has her first child at age 15 or below are roughly 30 percent less than the earnings of a woman who has her first child at 19 or 20. The younger a girl is when she first marries, the higher her probability of separation or divorce. A girl who marries at age 14 to 17 is two to three times more likely to experience divorce or separation than one who marries in her early twenties.

In 1975, about half of all mothers in ADFC families were women who had their first child during adolescence, and of all children born out of wedlock, almost 60 percent end up on welfare.

Teenage pregnancy poses serious health risks for a child and its mother, particularly younger mothers. Half of pregnant teenagers age 15 to 17 receive no prenatal care until the second trimester; 6 percent of pregnant teenagers under 15 receive no prenatal care at all. A baby born to a teenage mother is more than twice as likely to die during the first year of life than a baby born to an older woman. The likelihood of low-birth weight babies is 30- to 50-percent greater for teenagers, and low birth weight is associated with a number of conditions that can cause lifelong health and disability problems—conditions like mental retardation.

These are sobering statistics, Mr. Chairman. Behind them lie personal tragedies and heavy social costs. Clearly, these human costs to mother and to child require national attention and national concern.

Consider the dimensions of the teenage pregnancy problem in America: The age at which puberty occurs has declined steadily. The average age of puberty in the United States today is 12.8 years for girls, but about 13 percent puberty at age 11 or younger. This means that some children reach puberty by the fifth grade.

In 1976, 11 million teenagers aged 15 to 19 had experienced premarital sexual intercourse at least once. For girls, the number was 4.2 million—40 percent of all girls age 15 to 19, up from 30 percent in 1971. Two out of three boys in that age category had experienced premarital sexual intercourse, and approximately 375,000 under age 15 had that experience.

Although the use of contraceptives among teenagers is increasing and often effective, 25 percent never use contraception. They may be ignorant about the risk of pregnancy, or may lack access to contraceptives. They may be motivated by personal or religious considerations. They may simply be careless. They may wish to become pregnant. Whatever the reasons, these adolescents who never use contraception are responsible for almost 60 percent of the premarital pregnancies to teenagers.

We estimate that about 1 million adolescent girls become pregnant each year, 1 in 10 aged 15 to 19, the great majority out of wedlock. Of these 1 million girls, 400,000 are 17 or under; 30,000 are 14 or younger. While some teenagers are married and wish to become pregnant, a substantial number of teenage pregnancies are unwanted; well over 300,000 teenage abortions were reported in 1976 to the Center for Disease Control.

Of these 1 million girls, 600,000 give birth. Even though 40 percent of these babies are born out of wedlock, 9 out of 10 unmarried mothers decide to keep their out-of-wedlock babies.

Finally, many teenagers who give birth get pregnant again quickly. Of all teenagers who give birth, fully 25 percent become pregnant again within 1 year, in spite of widely available contraceptives; a far higher percentage become pregnant again within 2 years of their first child's birth.

Mr. Chairman, scarcely anyone—liberal or conservative, permissive or restrictive—can read these figures about teenage pregnancy without a sense of shock and melancholy. Whatever our opinions about adult sexuality and morality, it is sad to contemplate the specter of children being suddenly and prematurely faced with the responsibilities of adults—of children becoming parents while they are still children.

What some in our society choose to call sexual liberation has brought with it some unhappy and tragic consequences for millions of teenagers: The pressure to experiment with adult behavior before they are ready emotionally, morally, or economically; to shoulder adult responsibility; the wrenching disruption of life and education caused by the unwanted pregnancy and its consequences. This is not liberation; it is a form of bondage—bondage for the child-mother and bondage for the mother's child.

I am acutely aware, Mr. Chairman, that Government cannot work miracles. We are confronting pervasive social forces—changing moral standards, the deterioration of traditional family life, the declining authority of institutions like the church and the school—and we live in a mass culture which treats sex not as a serious personal responsibility, often not even as an act of love, but as a glittering consumer item to be exploited. Our society today is one in which personal self-discipline is more necessary than ever, and less popular than ever.

And we must recognize also that teenage pregnancies are often linked with other pernicious social problems: Poverty, unemployment, poor education, family breakdown.

All this means that there are limits to what Government can accomplish. Nevertheless, we believe that a concerned and compassionate Government should do what it can to reduce the social costs and the toll of human suffering caused by premature sexual activity and unwanted pregnancy among teenagers.

This legislation constitutes an acceptance of that responsibility. The bill reflects what we believe is a consensus among people who know the problems associated with teenage pregnancy. Our bill also draws upon legislative proposals and work that has been done by this committee and its subcommittees chaired by Senators Cranston and Kennedy.

It is important to stress at the outset that the administration's total initiative on teenage pregnancy is much broader than this legislation. We have proposed as part of the 1979 budget an expansion and targeting of teenagers of a number of existing programs, such as family planning, medicaid, maternal and child health, community health centers, education and HEW-funded research. In fiscal 1979, we have requested a total of $344 million for programs to address the pressing problems of teenage pregnancy, an increase of $148 million over current efforts.

The basic elements of S. 2910, this legislation, can be briefly summarized. It authorizes HEW to make project grants for up to 5 years to groups committed to two purposes: Preventing unwanted teenage pregnancies, and helping those teenagers who become pregnant. Grantees may be State and local agencies, community health centers, family planning clinics, schools, churches, teenage centers, residential care facilities, and other similar groups.

To qualify for a grant, local projects will have to document the magnitude of the teenage pregnancy problem in their community, describe the resources available to address it, discuss the way in which they will link and improve these services, and provide a plan for evaluating the effectiveness of their efforts.

The program is based upon four core principles. It pursues two closely related goals: The prevention of unwanted pregnancies, and the care of pregnant teenagers and teenage parents and their babies. It encourages expanded and comprehensive services for adolescents at risk of initial and repeat pregnancies and in need of pregnancy-related care. It encourages local experimentation with a variety of innovative approaches to designing, delivering, and coordinating pregnancy prevention and care in ways best suited to individual community needs. It builds, to the maximum feasible extent, upon existing resources and institutions at the Federal, State, and local levels.

Let me return to the four central purposes of the legislation and discuss them in greater detail. First, prevention: Prevention is our first and most basic line of defense against unwanted adolescent pregnancy. The Department's preventive strategy takes several forms, including education on the responsibilities of sexuality and parenting, and family planning services.

We anticipate that a significant portion of the $60 million budgeted for our proposed program will go to projects providing such family planning and educational services. In addition, we have budgeted for substantial increases in fiscal 1979 in family planning for teenagers in the Title X community health centers and maternal and child health programs, as well as expanding medicaid coverage for approximately 280,000 teenage girls.

But even with expanded family planning and education, many teenagers will continue to become pregnant. Young people, for example, who use contraception only sometimes—most or all of whom, obviously, have access to contraceptives—are resposible for more than one-third of adolescent pregnancies. Of those who never use contraception, only 30 percent cite unavailability as a reason for their nonuse.

When, despite our efforts at prevention, these young people do become pregnant, our concerns must shift. First, we must insure that both mother and child are healthy, and that the new family can strive toward a self-sufficient and productive future. Second, we must attempt to prevent the unwanted second and third pregnancies which often quickly follow the first.

Achieving those two objectives will require a variety of services, such as prenatal care, parenting and other education, and job counseling, as well as primary prevention services.

Second, comprehensive services: Almost all people with experience in dealing with the problem agree that for many adolescents, only

comprehensive services will succeed in meeting the objectives I have just discussed. There are several reasons why comprehensive services are important:

Many adolescents will not seek family planning help on their own, but can be attracted by other services, such as health care, counseling, or legal services. In a comprehensive setting, the agency providing services can then assure that they receive family planning help as well. Those familiar with teenage problems tend to agree that many teenagers who need and receive contraceptive information and counseling originally come to their programs seeking other services, such as vocational or legal counseling, social services, or recreation. In particular, such comprehensive services can begin to attract teenage boys into prevention and care programs.

Adolescents in danger of initial and repeat pregnancy have various and interrelated needs. The Center for School Age Mothers and Their Infants, associated with the Johns Hopkins Medical Center in Baltimore, provides pre- and post-natal care, primary health care, vocational counseling, family planning, parenting education, and other services. This program has demonstrated considerable success in reducing the incidence of low-birth weight babies, school dropouts, and repeat pregnancies. A similar program, the New Futures School in Albuquerque, has reduced the 1-year repeat pregnancy rate to only 8 percent, as compared with the 25 percent for this population at large, and more than 70 percent of the mothers in the Albuquerque program return to school after the birth of the child.

The work done by other programs, such as the Brookside Family Life Center in Boston, Mass., and the four centers of the Delaware adolescent program, suggest that a comprehensive approach—including education, day care, medical care, and vocational and social services—can yield the most successful results.

The bill itself lists several examples, and I quote:

> • • • family planning services, education at the community level concerning sexuality and the responsibilities of parenthood, health, mental health, nutrition, education, vocational, and employment counseling, prenatal and postpartum health care, residential care for pregnant adolescents, and services to enable pregnant adolescents to remain in school or to continue their education.

Third, encouraging innovative service systems: Clearly, there is no single answer to the complex adolescent pregnancy problem. We are convinced that successful approaches will be devised in local communities, not in Washington. For this reason, the bill provides flexibility to fund different types of grantees with different approaches, different emphases and different mixes of services. This diversity will insure that the program is not locked into a single type of service delivery system, and that it can be tailored to the needs of particular communities.

Fourth, building on existing institutions and resources: The $60 million authorized by this legislation will not go very far unless it is used to call forth additional funds from other programs and sources, Federal, State, and local. The bill specifically requires this. Where pregnancy prevention and care programs already exist in a community, the bill will primarily encourage links among them and strengthen those links where necessary. When a community lacks essential services, however, program funds may be used to provide them. The bill

specifically provides for a gradual decline in Federal support for particular projects. The purpose of this provision is to stimulate local support alone which can assure success. We will, however, be flexible about this requirement and permit adjustments in appropriate cases.

Mr. Chairman, adolescent pregnancy is one of the most complex, persistent, and poignant problems facing our society today. The power which Government possesses to deal with it, I must emphasize, is limited. Nonetheless, we believe that this administration legislation—the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978—together with the Department's expansion and retargeting of existing programs, represents an important start toward real solutions. The cost of the program, we think, must be measured against the far greater and harsher social costs of going nothing beyond our current efforts.

The role of Government must necessarily be limited when we approach a problem that deals with private lives and private behavior. But when the social costs and consequences of a problem are so great, we must not fail to take what steps we can. This legislation represents our effort to take those steps. We are gratified by the support that this initiative has already attracted among the Members of the Congress and particularly many members of this committee, and we intend to work closely with the Congress and with this committee in the coming weeks to insure passage of the legislation.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Secretary.

[The prepared statement of Secretary Califano follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

TESTIMONY OF

SECRETARY JOSEPH A. CALIFANO, JR.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

BEFORE THE

SENATE HUMAN RESOURCES COMMITTEE

June 14, 1978

Mr. Chairman, I am pleased to appear before this Committee to testify in support of the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978.

On behalf of President Carter and the Administration, let me express appreciation for the high priority the Committee has accorded this bill despite your demanding schedule.

Teenage pregnancy -- the entry into parenthood of individuals who are often barely beyond childhood themselves -- is one of the most serious and complex social problems facing our nation today.

For most of us, the birth of a child is an occasion of great joy and hope, an investment in the future, a consecration of life. But for hundreds of thousands of teenagers -- particularly the majority who are unmarried -- the birth of a child can usher in a dismal future of unemployment, poverty, family breakdown, emotional stress, dependency on public agencies, and health problems for mother and child.

Consider what is likely to befall the teenage mother:

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- Eight of ten women who have become mothers by age 17 never complete high school. Such women are more likely to encounter serious difficulties -- the first of which is unemployment.

- The younger a woman is when her first child is born, the less money she is likely to earn compared to her classmates who become mothers later in life. The annual earnings of a woman who has her first child at age 15 or below, for example, are roughly 30 percent less than the earnings of a woman who has her first child at 19 or 20.

- The younger a girl is when she first marries, the higher her probability of separation or divorce. A girl who marries at age 14 to 17, for example, is two to three times more likely to experience divorce or separation than one who marries in her early 20's.

- In 1975, about half of all mothers in AFDC families were women who had their first child during adolescence. Of all children born out-of-wedlock, almost 60 percent end up on welfare.

Teenage pregnancy poses serious health risks for a child and its mother -- particularly younger adolescent mothers.

- Half of pregnant teenagers age 15-17 receive no prenatal health care until the second trimester; 6 percent of pregnant teenagers under age 15 receive no prenatal care at all.

- A baby born to a teenage mother is more than twice as likely to die during the first year of life than a baby born to an older woman.

- The likelihood of low-birth-weight babies is 30 to 50 percent greater for teenagers. And low birth-weight is associated with a number of conditions which can cause lifelong health and disability problems, such as severe mental retardation.

These are sobering statistics. Behind them lie many personal tragedies and heavy social costs. Clearly these human costs require national attention and national concern. Consider the dimensions of the teenage pregnancy problem in America:

- The population aged 10 to 19 has swelled over the last 25 years, and now exceeds 40 million young people. Over the next 15 years, the number of adolescents will decrease slightly. But it will increase thereafter, when the babies born in the mid-1970's and early 1980's reach their teens.

- The age at which puberty occurs has declined steadily, largely reflecting improvements in nutrition. The average age of puberty in the United States today is 12.8 years for girls, but about 13 percent reach puberty at age 11 or earlier. This means that some children reach puberty by the fifth grade.

- In 1976, eleven million teenagers aged 15-19 had experienced premarital sexual intercourse at least once. For teenage girls aged 15-19, the number was 4.2 million: 40 percent of all girls 15-19 -- up from 30 percent in 1971. Two out of three boys in that age category had experienced premarital sexual intercourse -- and approximately 375,000 girls under age 15.

- The use of contraceptives among teenagers is widespread, increasing, and often effective. Nevertheless, for a variety of reasons, 25 percent of teenagers never use contraception. They may be ignorant about the risk of pregnancy, or may lack access to contraceptives. They may be motivated by personal or religious considerations. They may simply be careless. They may wish to become pregnant. Whatever the reasons, these adolescents who never use contraception are responsible for almost 60 percent of the pre-marital pregnancies to teenagers. In addition, 42 percent do not use contraception regularly; and of those teenagers who do use contraceptives, many use methods that have relatively high failure rates.

- We estimate that about one million adolescent girls -- one in ten aged 15-19 -- become pregnant each year, the majority out of wedlock. Of these one million girls, 400,000 are 17 or under; 30,000 are 14 or under. While some teenagers are married and wish to become pregnant, a substantial number of teenage pregnancies are unwanted; well over 300,000 teenage abortions were reported in 1976 to the Center for Disease Control.

- Of these one million girls, 600,000 give birth. Even though 40 percent of these babies are out of wedlock, nine out of ten unmarried mothers decide to keep their out-of-wedlock babies.

- Finally, many teenagers who give birth get pregnant again quickly. Of all teenagers who give birth, fully 25 percent become pregnant again within a year -- in spite of widely available contraceptives, a far higher percentage become pregnant again within two years of their first child's birth.

Although annual births to teenagers, like those to women in general, are declining, the number of pregnancies experienced by teens is continuing to increase.

Scarcely anyone -- liberal or conservative, permissive or restrictive -- can read these figures about teenage pregnancy without a sense of shock and melancholy. Whatever our opinions about adult morality and sexual standards, it is sad to contemplate the specter of children being suddenly and prematurely faced with the responsibilities of adults -- of children becoming parents while they are still children.

What some in our society choose to call sexual liberation has brought with it some unhappy consequences for millions of teenagers: the pressure to experiment with adult behavior before they are ready -- emotionally, morally, or economically -- to shoulder adult responsibility; the wrenching disruption of life and education caused by an unwanted pregnancy and its consequences. This is not liberation; it is a form of bondage for the child-mother and the mother's child.

I am acutely aware, Mr. Chairman, that government cannot work miracles. We are confronting large social forces: changing moral standards, the declining authority of institutions like the church and the school, and a mass culture that treats sex not as a serious personal responsibility -- and often not even as an act of love -- but as a glittering consumer item to be exploited. Our society today is one in which personal self-discipline is more necessary than ever -- and less popular than ever.

And we must recognize also that teenage pregnancies are often linked with other, pervasive social problems: poverty, unemployment, poor education, family breakdown.

All this means that there are limits to what government can accomplish. Nevertheless, I believe that a concerned

and compassionate government should do what it can to reduce the social costs and the toll of human suffering caused by premature sexual activity and unwanted pregnancy among teenagers.

This legislation constitutes an acceptance of that responsibility. The bill reflects what we believe is a consensus among knowledgeable people who know the problems associated with teenage pregnancy. Our bill also draws upon legislative proposals that have been previously advanced.

It is important to stress at the outset that the Administration's total initiative on teenage pregnancy is much broader than this bill. We have proposed as part of the 1979 budget an expansion and targeting on teenagers of a number of existing programs, such as family planning, Medicaid, maternal and child health, community health centers, education, and HEW-funded research. In fiscal 1979, we have requested a total of $344 million for programs to address the pressing problems of teenage pregnancy: an increase of $148 million over current efforts.

The basic elements of S. 2910 can be briefly summarized:

- It authorizes HEW to make project grants for up to five years to groups committed to two purposes: preventing unwanted teenage pregnancies, and helping those teenagers who become pregnant. Grantees may be State and local agencies, community health centers, family planning clinics, schools, churches, teenage centers, residential care facilities, and other such groups.

- In order to qualify for a grant, local projects will have to document the magnitude of the teenage pregnancy problem in their communities, describe the resources already available to address it, discuss the way in which they will link and improve these resources, and provide a plan for evaluating the effectiveness of their efforts.

- The legislation requires Federal and state programs relating to adolescent pregnancy to be better coordinated at both levels and requires HEW to evaluate activities under the Act.

The program is based upon four core principles:

First, Prevention: Prevention is our first and most basic line of defense against unwanted adolescent pregnancies. The Department's preventive strategy takes several forms, including education on the responsibilities of sexuality and parenting, and family planning services.

We anticipate that a significant portion of the $60 million budgeted for our proposed program will go to projects providing such family planning and educational services. In addition, we have budgeted for substantial increases in fiscal 1979 in family planning for teenagers in the Title X, Community Health Centers, and Maternal and Child Health programs, as well as expanding Medicaid coverage (including family planning) for approximately 280,000 teenage women.

But even with expanded family planning and education, many teenagers will continue to become pregnant. Young people, for example, who use contraception only "sometimes" -- most or all of whom, obviously, have access to contraceptives -- are responsible for more than one third of adolescent pregnancies. Of those who "never" use contraception, only 30 percent cite unavailability as a reason for their non-use.

When, despite our efforts at prevention, these young people do become pregnant and decide to give birth, our concerns must shift.

- First, we must ensure that both mother and child are healthy, and that the new family can strive toward a self-sufficient and productive future.

- Second, we must attempt to prevent the unwanted second and third pregnancies which often quickly follow the first.

Achieving those two objectives will require a variety of services, such as pre-natal care, parenting and other education, and job counseling, as well as primary prevention services. By combining both approaches, this legislation, we believe, gives us a more effective strategy.

Second, Comprehensive Services: Almost all people with experience in dealing with the problem agree that for many adolescents, only comprehensive services will succeed in the prevention and meeting the objectives I have just discussed. There are several reasons why comprehensive services are important:

- Many adolescents will not seek family planning help on their own but can be attracted by other services, such as health care, counseling, or legal services. In a comprehensive setting, the agency providing services can then assure that they receive family planning help as well. Those familiar with teenage programs tend to agree that many teenagers who need and receive contraceptive information and counseling originally come to their programs seeking other services, such as vocational or legal counseling, social services, or recreation. In particular, such comprehensive services can begin to attract teenage boys into prevention and care programs.

- Adolescents in danger of initial and repeat pregnancy have various and interrelated needs. The Center for School Age Mothers and Their Infants, associated with the Johns Hopkins Medical Center in Baltimore, provides pre- and post-natal care, primary health care, vocational counseling, family planning, parenting education, and other services. This program has demonstrated considerable success in reducing the incidence of low-birth weight babies.

school drop-outs, and repeat pregnancies. A similar program, The New Futures School in Albuquerque, has reduced the one-year repeat pregnancy rate to only eight percent. And more than 70 percent of mothers in the program return to school after the birth of their child.

The work done by other programs, such as the Brookside Family Life Center in Boston and the four centers of the Delaware Adolescent Program, suggest that a comprehensive approach -- including education, day care, medical care and social services -- can yield the most successful results.

This legislation requires each project to describe in detail how it will make multiple services available, either at a single site or through a network of linked providers in the community. Although no single project will be required to offer all types of services, there are many that may be offered.

The bill lists several examples:

". . . family planning services, education at the community level concerning sexuality and the responsibilities of parenthood, health, mental health, nutrition, education,

vocational, and employment counseling, prenatal and postpartum health care, residential care for pregnant adolescents, and services to enable pregnant adolescents to remain in school or to continue their education."

Third, Encouraging Innovative Service Systems: Clearly, there is no single answer to the adolescent pregnancy problem; we are convinced that successful approaches will be devised in local communities, not in Washington. For this reason, the bill provides flexibility to fund different types of grantees with different approaches, different emphases, and different mixes of services. This diversity will ensure that the program is not locked into a single type of service delivery system, and it can be tailored to the needs of particular communities.

This flexibility, however, must be accompanied by a clearly defined set of priorities and by requirements that grantees document their need for support and their capacity to reduce the incidence of unwanted adolescent pregnancy. The bill lists seven criteria which will be considered in ranking and selecting grantees; it also prescribes the requirements for grant applications. Funding decisions will be made by the Public Health Service in conjunction with the Office of Education and the Office for Human Development Services. Communities which meet these funding criteria

will be provided appropriate training and technical assistance. We intend that currently successful projects will be heavily utilized in training workers for other other projects. After its launching, each project will be carefully evaluated to ensure that effective program designs are identified and that what we learn can be put to work in other communities.

Fourth, Building on Existing Institutions and Resources: The $60 million authorized by this legislation will not go very far unless it is used to call forth additional funds from other programs and sources, Federal, state, and local. The bill specifically requires this. Where pregnancy prevention and care programs already exist in a community, the bill will primarily encourage links between them and strengthen those links where needed. When a community lacks essential services, however, program funds may be used to provide them. The bill specifically provides for a gradual decline in Federal support for particular projects; the purpose of this provision is to stimulate the local support which alone can ensure success. We will, however, be flexible about this requirement and permit adjustments in appropriate cases.

Mr. Chairman, adolescent pregnancy is one of the most complex, persistent, and poignant problems facing our society today. The power which government possesses to deal with it, I must emphasize, is limited. Nonetheless, we believe that this Administration legislation -- the Adolescent the Health, Services, and Pregnancy Prevention and Care Act of 1978, together with the Department's expansion and retargeting of existing programs -- represents an important start toward real solutions. The cost of the program, we think, must be measured against the far greater and harsher social costs of doing nothing beyond our current efforts.

The role of government must necessarily be limited when we approach a problem that deals with private lives and behavior. But when the social costs and consequences of a problem are so great, we must not fail to take what steps we can. This legislation represents our effort -- a carefully constructed and long-considered effort -- to take those steps.

We are gratified by the support that this initiative has already attracted among members of Congress and we intend to work closely with the Congress in the coming months to ensure passage of this legislation.

* * * *

Mr. CHAIRMAN. Will Dr. Lulu Mae Nix, from your Department, be speaking to us?

Mr. CALIFANO. No.

The CHAIRMAN. Will she be here for some of the details of the application of the program and how it will work?

Mr. CALIFANO. She is here, as is Peter Schuck, who is the Deputy Assistant Secretary for Planning and Evaluation. Dr. Nix is not full time with HEW yet.

The CHAIRMAN. Senator Kennedy was not here to make an introductory statement. Senator Kennedy, as chairman of our Subcommittee on Health, would you care to give your remarks?

Senator KENNEDY. Thank you, Mr. Chairman. I am sure the committee wants to get into questioning the Secretary. I wanted to just express my appreciation for the commencing of these hearings.

Similar legislation was introduced some 3 years ago, and we were unable to get the focus or the attention that we have been able to get on this particular legislation; we did not have a Secretary of HEW who was strongly committeed to it, or a President who was strongly concerned about the problem. And I think what we have seen over the period of years is that where we have had the support for the prevention of pregnancies, we have still seen the explosion of the numbers of these teenage girls who, although aware of the prevention opportunities and still desire to have a child.

And it seems to me that what we are attempting to fashion here is the kind of coordination of various services and facilities to make sure that that young person, that young girl who is going to bring the pregnancy to term, is going to be given the kinds of support services that she needs. And we must see that the child, that the baby is going to have the reduced health hazards both during the period of the pregnancy and at the time of birth. And we know from the various programs that have taken place—I think the Johns Hopkins illustration and the examples in Delaware, or the other illustrations in my own State of Massachusetts—that there can be an enormously positive impact in terms of the health and the well-being of the baby, in terms of reducing the second pregnancies, and in terms of keeping these young people away from the dependency on the community in terms of welfare or other social services; it permits them to gain employment or to continue employment.

So, perhaps from the point of view which seems to be most on the minds of at least some Americans today, from a dollar-and-cents point of view, it makes sense. But I think, most importantly, from a humane and from a health point of view, it makes a good deal of sense. This is not to question that we do not have some very complex and difficult issues that we are going to have to resolve. But this has been an issue which I have been interested in for a long time. Senator Bayh was a cosponsor of that initial legislation some 3 years ago. I am glad we are having these hearings today, and I look forward to developing some of the points with the Secretary of HEW, and I welcome the opportunity that this full committee is giving to this particular issue.

Thank you, Mr. Chairman.

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Opening Statement of Senator Kennedy

Senator Kennedy. This morning we are going to discuss an increasingly important issue which faces our society—the epidemic of teenage pregnancy. We will hear why even when family planning services are available to teenagers, some utilize these services and others do not. We will hear why so many young girls, who are still children themselves, become pregnant a second, third, or fourth time, and we will hear how comprehensive adolescent pregnancy care centers have been successful at preventing these tragic repeat pregnancies.

Many have failed to recognize the serious dimensions of the present situation: In 1976, 11 million teenagers were sexually active; 1 million females 19 and under become pregnant each year; and 600,000 of these women have live births.

I have recently seen two studies dealing with teenage births in North Carolina and the District of Columbia which I believe illustrate the magnitude of the problem.

In North Carolina in 1975, 1,734 women 15 and under had babies. For 83 of these young girls, this birth was their second child and for 2 this birth was their third. It is hard to imagine a 15-year-old with three children. By the age of 16, 322 girls had their second baby; 20 had their third, and 4 had their fourth child.

This situation is not much better in the District of Columbia. In 1976, more than 25 percent of the live births were to girls under the age of 20. Of these young mothers, 90 were 14 years old or younger and 486 of these teenagers in 1976 had their second, third, or fourth child.

I have long been interested in legislation such as the bill we are discussing today. In 1975, I introduced the National School-Age Mother and Child Health Act. At that time we recognized that the problem was much broader than a health problem. The birth of a child to a school-age mother has tremendous consequences to the mother, the father, and the child. Pregnancy among teenagers is the leading cause of high school dropouts among girls. It imposes a terrible burden on the girl, as well as a social burden on society. And for over half these girls, the birth of a child begins a cycle of dependency upon public welfare.

The health problems are also severe. The younger the mother the more likely the child is to be born premature, to be underweight, and to suffer a wide variety of other health and social disadvantages.

The Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978 complements and builds upon a number of existing programs within the Department of Health, Education, and Welfare. During the course of today's testimony we will hear about many of these programs—family planning, material and child health, community health centers, education, and research. Many of these programs are excellent. And yet, when we hear from teenagers themselves and from the panels providing services to teenagers, we will see the existing programs are not enough, and they are poorly coordinated.

S. 2910, which I was pleased to introduce on behalf of the administration, will aid in the expansion of programs dealing with both services to pregnant teenagers as well as primary family planning services. This bill encourages experimentation at the local level with a variety of innovative approaches to designing, delivering, and coordinating services.

I want to commend Secretary Califano on the selection of Lulu Mae Nix as coordinator of the Department's new adolescent pregnancy initiative. Dr. Nix testified before the Health Subcommittee in 1975. I have long been impressed with the work she has done with the Delaware Adolescent Program, Inc. [DAPI]. Under her leadership, it has become the Nation's only statewide program serving pregnant teenagers. DAPI is a comprehensive program and has had remarkable success since it began in 1969 with a grant of $22,500 from the Junior League of Wilmington. DAPI's success was summarized in a recent 5-year-after-birth study comparing girls in the program and others of the same age and background:

Over 70 percent of the DAPI teenagers completed high school while only 27 percent of those not in the program graduated from high school.

Only 30 percent of the DAPI group had a repeat pregnancy within 5 years while over 50 percent in the other group had a second pregnancy.

In regards to sick baby care—DAPI mothers used private physicians in 77 percent of the cases and relied on hospital emergency rooms in only 10 percent of the cases. By contrast, the non-DAPI group used hospital emergency rooms in 62 percent of the cases.

If Dr. Nix can do all this starting with $22,500, we are looking forward to seeing what she can do with $60 million.

In addition to DAPI there are other model programs including the Johns Hopkins Center for School-Aged Mothers and Their Infants in Baltimore, the Brookside Family Life Center in Jamica Plain, and the New Futures School in Albuquerque. We will hear today testimony of their success. And we will learn that with more centers like these we can help, in a most direct way, young mothers who in many cases are still children themselves.

Today, we will also hear from a panel of teenagers. Their backgrounds are varied, and the stories they will relate are all different. But all have one thing in common—at a very young age they have had to make serious decisions regarding their own sexuality and the responsibility of becoming a parent.

The CHAIRMAN. Thank you, Senator Kennedy.

Mr. Secretary, you have indicated that your budget for this area of social concern is much broader and comprehensive than this bill. This bill calls for an authorization figure of $60 million.

Mr. CALIFANO. In the first year, Senator.

The CHAIRMAN. This is a national figure, and would be directed to the States and the communities?

Mr. CALIFANO. That is correct, sir.

The CHAIRMAN. Now, I notice that this legislation places an emphasis on the linkage of existing services. Do you envision the application of these resources of $60 million to generate new services and new activity to address this social situation and the problems that arise out of it?

Mr. CALIFANO. We provide in the bill for a 30-percent match—70 percent Federal funds, 30 percent matching by the local community. So, $15 million will be generated. Now, whether that will be a new $15 million or people will take existing programs and use those funds to match, I cannot answe But if you take the $85 million applied to this

problem, we estimate that it will reach, roughly, an additional 113,000 to 115,000 adolescents, who will be able to get comprehensive services. That is based on an estimate, Senator, that it will cost about $750 per year per adolescent to provide these services. But beyond that, our belief, from looking at the programs I mentioned and some other programs, is that when you link programs together, we will have something more than the sum of the parts and we will have a much more effective way of dealing with the problem.

The CHAIRMAN. As you know this committee is in the process of developing and expanding youth employment programs. It would seem to me, that part of the teenage dilemma of today is the inactivity, the unemployment, the lack of opportunity to be doing something of value and importance, coinciding with a period of dynamic desire to be active among young people.

It would seem to me if these other efforts are in place and are reaching our young people, it should be part of the youth response to a productive and wholesome life, without the problems of idleness. In your opinion Mr. Secretary, is there a relationship?

Mr. CALIFANO. Yes, I think there is, Mr. Chairman. And we think what you have been doing and what this committee is doing in the youth unemployment area is of enormous importance and significance to the general problem that faces young people in this country and will be helpful in any adolescent pregnancy program of this kind. Indeed, one of the comprehensive services we would want to provide would be vocational counseling. And one of the things you are providing in the Youth Unemployment Act is funding so that we can experiment with different educational-job relationships with high school students in a way that we are not able to now. So, it will be helpful.

The CHAIRMAN. Well, I have to be impressed with your understanding of the dimension of the situation here. The statistical knowledge that you have is impressive; that is, the quantitative measure of teenage pregnancy. In those terms, we know the magnitude of the problem; but to understand some of the other approaches of meeting the problem is very important.

Let me turn to my colleagues here. Senator Cranston?

Senator CRANSTON. I yield to Senator Kennedy.

Senator KENNEDY. To pose the question, Mr. Secretary, I think what has to be on the minds of an awful lot of Americans, is how can we, in the wake of proposition 13, think about a new program that is targeted on people who are generally the poorest people in our society, and in the lower socioeconomic range of our system. This, of course, does happen to others in the higher incomes, but generally what we are talking about are children of welfare mothers. The attitude that is abroad, at least in some parts of the country, is that this particular group of young teenagers—perhaps some people in middle America question their moral values or standards.

Why is the administration coming up with a new program to try and deal with this issue, with this problem, with this question? Parts of this country are really turning their backs, so to speak, on the neediest people in our society. And why is this program really basically needed or justified, and how can you, managing the biggest group of social programs in the country, think that it is justified?

I have my own views about it—the need for it—but I think that we ought to hear from you, as the principal spokesperson from the administration, about the need from a humane point of view, from an economic point of view, from a health point of view. I think that you are going to have to make this case, because those of us who are supporting the legislation, like myself, are also going to have to make the case. I think that you had better be the one to get started off, with the opportunity to do it, in the best way that you can.

Mr. CALIFANO. Senator, I think particularly in a time when the resources to apply to difficult and troublesome social problems are limited, this moves very high on the agenda of this Nation's social problems. I believe from the human point of view, from the economic point of view, from the health point of view, this legislation is imperative, and the attention and devotion of resources to this problem will save this country not simply untold human suffering, but tremendous amounts of money over time.

For example, I indicated that we believe we can provide comprehensive services that have been demonstrated to be effective in a variety of settings for about $750 per year for an adolescent and her baby, or the adolescent alone; that is roughly the average amount. I would compare that with the several thousand dollars per year that this country pays for every mother and child on welfare.

Second children who are born to young girls tend to have much higher health risks, and those health risks affect the child, in many cases, for the rest of its life—mental retardation, serious mental retardation being one of the most notable; that is often caused by low birth weight. It also tremendously scars the individual girl. It scars her in human terms, obviously, but in economic terms, she becomes less productive for our society; she has much more difficulty getting employment; there is a much higher unemployment rate among girls who have babies, and they earn much less over the course of their lives. So, I think this investment—a relatively modest additional and initial investment—that we are suggesting of $60 million in a new program will pay enormous dividends for the American people.

Senator KENNEDY. You are going to supply for us a breakdown in terms of what have been the results of these various pilot programs, projects. The ones I am familiar with—particularly with Johns Hopkins—bear out the people that have been kept off welfare, as compared to those that have brought their babies to term and had virtually no kind of supporting facilities.

But I think we ought to get a rather hard kind of economic analysis about these comparative cost factors. You have some in your testimony, but I think we ought to develop that. We have a number of people who want to ask questions on it, but I want to get more information from you on the justification of it.

I think also we ought to do the analysis in terms of toxemia and anemia, in terms of what it costs for these newborn children that are born without these kind of support services and what basically ends up being the cost to the communities, because I do not know any place in the country that is just going to not treat these children. We need more information in terms of the various kinds of costs, evaluations in those areas. And, of course, it is extremely difficult to put a cost fac-

tor on the human terms—on what it means psychologically for the mother in being given these kinds of support and not given the support.

If it has all the beneficial factors that you mention here and if we are talking about $750 per person of support, and given the magnitude of the problem, then why are you not requesting more, if it is so cost efficient? Why are we not going to do better, then, if it is this good of a deal?

Mr. CALIFANO. Well, Senator, as I noted in my opening statement, we are devoting $344 million to this problem. That is an increase of $148 million we are requesting in fiscal 1979 over fiscal 1978. I think that is about as fast as we can go. We will be starting a new program. In later years, the legislation provides for such funds as the Congress may authorize; the lid is lifted, and we will be back as we see how it works. That is why we came in with that figure.

Senator KENNEDY. Well, we are on a short time frame, I understand. I would like to come back to you.

But I do think, in conclusion of my time in this first round, that the real challenge in terms of the hearing now on this program and on other programs in your Department is going to be the real leadership that you and others are going to provide to deal with the real frustrations of people who are out in the countryside and feel that this is just going to be one more program, and that it is not justified or warranted or even cost effective. And I think it is going to be essential both for you and the President and the rest of us who support it to be able to provide some degree of leadership to show in human terms, as well as in cost terms, what the meaning is going to be on young teenage women in this society.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Schweiker.

Senator SCHWEIKER. Thank you, Mr. Chairman.

Mr. Secretary, the bill does not specifically spell out the relationship between this program and the present Title X, Public Health Service Act, family planning program. And my question is: How do you plan to coordinate the two, rather similar programs and insure that there will not be duplication, overlap, and competition?

Mr. CALIFANO. Well, both those programs are under my jurisdiction. The bill also, even more broadly than the title X, family planning program, gives the Secretary of HEW authority to coordinate programs in this area generally. We have already begun to do that. And second, we are creating an office to deal with the teenage pregnancy problem, which Dr. Nix will head; and which will coordinate all those activities throughout the Department. So, I think we will be careful to coordinate all these programs.

Senator SCHWEIKER. Well, as I understand then, you are setting up two—there is already one office, obviously, under you, and you are setting up another office under you in this area.

Mr. CALIFANO. For the time being, Senator Schweiker, as we begin, it is my belief that we should have a separate office that should report directly to the Surgeon General and the Assistant Secretary for Health, and that as we begin this problem, I do not believe it should be part of the Deputy Assistant Secretary for Population Affairs' Office. So, yes, I am.

Senator SCHWEIKER. Are there any general policy separations that you envision to spell out in terms of any implementation regulations in this area? You do have the authority in the bill, but it does not state specifically how that might be achieved. And I am just concerned—it is not an easy thing to do, I would think.

Mr. CALIFANO. Well, I think it is relatively easy to do within our own Department, where all the jurisdiction is under one person. It is more difficult to do throughout the Government, even with a legislative mandate. But I think the legislative mandate will help there.

Senator SCHWEIKER. And you are saying that it is your very specific and clear intent to do exactly that, because both are under you.

Mr. CALIFANO. That is correct, Senator.

Senator SCHWEIKER. OK. The bill is vague with respect to the target population concerned. How do you plan to focus the program so that maximum effectiveness is achieved? Senator Kennedy just asked, if you should not have more than $60 million—and I guess if you envision the program the way I read it—you should probably have substantially more than $60 million to accomplish what the general concepts are.

My question to you is: How do we spend the $60 million wisely without some kind of focus? Obviously, we cannot meet with $60 million all of the needs of teenagers in the country. And assuming that that is true, how do we focus so that we use the $60 million wisely?

Mr. CALIFANO. Senator, the bill has a specific section which sets up seven guidelines under which we are to determine priorities—areas of high adolescent pregnancy, areas of high incidence of poverty, areas where the community is involved—and it gives us seven general guidelines for us to focus on in terms of deciding what population to target on.

It will not, as you have noted, provide enough funds to reach all of that population, but I would submit, Senator, that while one could say, just expand the $60 million and reach 1 million of the population, or whatever population you ultimately wanted to reach, instead of 135,000, or 113,000, you can only start these programs so fast; there is a limit to the institutional and organizational capability of beginning a program, and we are asking for this $60 million in the first year. That is why, in later years, we have left the authorization open ended.

Senator SCHWEIKER. The bill does establish an evaluation program, but, as I read it, does not require an evaluation component for each program. I wonder if some oversight evaluation really is not desirable in that respect. Lack of evaluation seems to be one of our problems in Washington generally. And since you do you have an evaluation program per se, could we not require an evaluation component for each program and to see, is it doing the job, is reaching the teens, is really responding to the needs?

Mr. CALIFANO. We will have an evaluation component with every program. Indeed, at the same time that we put this office fully into operation, we will start an evaluation of the office itself in Washington. So, I agree 100 percent with that. I think the bill does, in effect, provide for that. If the language is not tough enough or strict enough, we have no objection to making it clear, because that is what I intend to do.

Senator SCHWEIKER. Finally, with regard to the $60 million figure, I know we are going to hear testimony later on that this is not enough,

but I am sure, serving on the Appropriations Committee, there will be opposition to $60 million.

So, my question to you is, how was $60 million arrived at, and is there any kind of a general breakdown of what will be funded, what goals will be achieved.

Mr. CALIFANO. Well, the $60 million was achieved in the process of arguing the budget out both within HEW and with the Office of Management and Budget. As far as what it would be spent on, the bill provides that no more than 50 percent of the funds appropriated under the bill can be used to fund new services. That is designed to put emphasis on encouraging linkages between existing services and maximizing their effectiveness, although the bill, I should note, also gives the Secretary of HEW authority to waive that provision in particular cases where he thinks it is appropriate. But as a benchmark, about half of it would go to new services; about half of it would go to linkages. But it will be hard to tell until we get the grant applications in and move out with them.

Senator SCHWEIKER. I might say on the OMB response that you gave me that to get $60 million out of OMB is a significant breakthrough, so I have to commend you on that. That certainly is a positive sign that the administration is interested in the bill.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Cranston.

Senator CRANSTON. Thank you, Mr. Chairman. I have just a few questions on how the administration will insure the flexibility that I discussed in my opening remarks, and how the Department plans to administer some of the discretionary authorities included in the legislation as it was introduced.

First, I am pleased your testmony indicates that family planning clinics are among the types of entities that can be used as a base for coordinating community services, even though, despite the suggestions that we made, S. 2910, as introduced, did not specifically list family planning clinics as eligible under section 104(a)(5). I hope we can correct this as we work on the bill.

I am also pleased that your testimony indicates that the Department's intention is to encourage innovative service systems by funding different types of grantees with diverse approaches. I think this, perhaps, should be spelled out more clearly in the legislation.

The legislation requires that a priority will be given to an applicant that can show evidence that it can bring the needed services together in a comprehensive, single-site project, or that can establish a well-integrated network of outreach to and services for adolescents. What do you envisage as meeting your criteria of a well-integrated network?

Mr. CALIFANO. Well, Senator, I think it will vary from location to location. I think it will be different, for example, in the rural areas than it will be in the cities. A well-integrated network would be a situation in which there were services either available in one place or in a neighborhood or in a community to deal with the whole person. One of the major concepts we are after is to treat these girls as entire people, not just treat one part of them, in effect; not just treat the pregnancy problem as purely a mechanical problem, but to treat them as human beings, so that they get counseling, they understand how

important education is; if there are human needs that they have which often lead to teenage pregnancy, to try and deal with the underlying human problems. So, that is what we are after.

Senator CRANSTON. I am certainly glad you are taking that broad approach.

Since the bill limits funding projects to no more than 5 years, do you envision the single-site projects becoming self-supporting during that time or by the end of it?

Mr. CALIFANO. We would like to encourage that. Hopefully, as the community saw that the program was working and if the community felt it was working, that is one way for us to measure the extent to which the community itself—State, local, and volunteer—believes that the program is working and worth the valuable effort. The bill does provide the authority for the Secretary to waive that 5-year limitation in certain circumstances.

Senator CRANSTON. How would the networks that you envision be supported after the 5 years had been run through?

Mr. CALIFANO. Well, they would be supported locally. It is not an unusual provision, Senator. We have the provision in the bilingual education programs; we have it in other HEW programs. It works with mixed effectiveness. Congress is not unknown to extend the 5-year period, or whatever the period is, as we get close to it.

Senator CRANSTON. Your statement indicates that where pregnancy prevention and care programs already exist in a community, the administration's bill would encourage links between them and strengthen those links where that is needed.

Do you have an estimate of the number of communities where sufficient services already exist, so that linking those services would be the most effective use of support under the proposed bill?

Mr. CALIFANO. We do not have a really good estimate, Senator. I can answer you and say that we estimate there are several hundred, but the fact is that we have not actually gone out; we have not actually done the kind of examination, except in a few cases, to give you a good answer.

Senator CRANSTON. Do you have an estimate of the number of communities where essential services are lacking and authorities under the proposed legislation would have to be used to establish those services?

Mr. CALIFANO. I cannot answer the question the way you put it, but I could give you this sense: We estimate that presently, today, there are about 120,000 adolescents who are receiving something approaching the kind of comprehensive services we are talking about, and that means there are literally hundreds and hundreds of thousands who are not.

If you took an average of—which is a very rough estimate—an average of 200 adolescents per facility, you would be at, I guess, 600 places in this country where there is something similar to these services.

Senator CRANSTON. What percent of the funds would go for networks and what percent for the establishment of services?

Mr. CALIFANO. Well, as the bill is written, it provides that no more than 50 percent of the funds can go for provision of services, and

that was designed to encourage the use of existing services and put a focus on networks. But the bill also does provide that the Secretary of HEW can waive that in appropriate cases.

Senator CRANSTON. How much do you estimate it would cost to establish a program in a typical community where essential services are pretty much totally lacking?

Mr. CALIFANO. I cannot give you a good number on startup expenses. Once a program has started up, we estimate a cost of about $750 per year per adolescent, and that is an average of adolescents with and without children.

Senator CRANSTON. Can you give us startup costs for the record?

Mr. CALIFANO. I will, yes, sir.

[The information referred to follows:]

How many adolescents could be served under the new legislation?

The cost range for both prevention and support programs is so great that any estimate as to the number of potential clients contains a high degree of error. The number of adolescents served will depend not only on the amount of project grant funds available but also on:

- the specific program model,
- the mix of prevention and support services,
- mobilization of other funding sources and linkages to already existing programs, and
- the needs of the specific target populations.

However, based on cost figure from currently operating programs we can provide the potential range of clients to be served—

Prevention Programs

Cost Per Client	Federal Share (70% of project)	Potential No. of Clients	Federal and Non Federal	Potential No. of Clients
$ 50	$60 M	1,200,000	$85.5 M	1,710,000
$ 80	$60 M	750,000	$85.5 M	1,068.750
$ 110	$60 M	545,000	$85.5 M	777,300

Support Programs

Cost Per Clients	Federal Share (70% of project)	Potential No. of Clients	Federal and Non Federal	Potential No. of Clients
$ 750	$60 M	80,000	$85.5 M	114,000
$1600	$60 M	37,500	$85.5 M	53,400
$3000	$60 M	20,000	$85.5 M	28,500

We anticipate that the actual number of clients served will reflect a combination of Prevention and Support programs. If 50% of the funding went to prevention programs and 50% to support programs at a per client costs of $80 and $750, respectively, then 415,000 adolesecents could be served for $60 M, and 591,375 adolescents for $85.5 M.

* See Attachment for explanation of what these costs figures provide. It is anticipated that for most programs the per client cost will be closer to the $750 COST figure than the $3000 cost figure. Reason for this assumption is that usually the two most expensive costs—medical services and academic or vocational education—will not be paid for out of the project grant funds but through other sources.

** This is a family unit count and includes service to the adolescent mother, her child, boyfriend or husband, and her family.

PER CLIENT COSTS

Q. What do you anticipate your per client cost will be for the program? You said $750 at your testimony—how can you do this so cheaply?

A. The cost of services depends critically on the mix of services afforded to an adolescent client. Currently, the range is very great—from less than $100 for certain family planning services to more than $3,000 for a broad array of pre-natal, delivery, post-partum and other services for pregnant teenagers.

1. For Primary Prevention Services, a project which would minimally include information about and access to contraception, counseling, and sex education outreach to schools or community, the cost range would be between $50 and $110 per client (this is based on existing program costs). Naturally, costs would be at the lower end of the range when primary prevention is an add-on to an existing multiple services program—costs would be at the higher end of the range when communities would have to develop or expand a variety of services.

2. For Support Services to pregnant adolescents —

   - We know that for five centers which offer some of a variety of services that should be provided in projects funded under the new legislation, the average cost is approximately $750 per client. These services include: special instruction for teenage parents; educational and vocational counseling; health counseling; well-baby care; counseling to adolescent mothers, fathers, and the parents of the adolescents; social services for pregnant girls and followup services for adolescent mothers; infant day care; family planning to avoid repeat pregnancies; and pregnancy prevention outreach to those not in the program.

   - The $750 average cost does not cover provision of all these services, however. If a single program offered all these services (listed above) plus psychological testing, meals to pregnant adolescents and mothers, some pre-natal care, health, counseling, well-baby care, and transportation for mothers and children,* the total annual cost would be approximately $1,600.

* Assumes all mothers receive all services except transportation, 50% use transportation, 40% of fathers use counseling and infant day care is limited to 15% of the mothers served.

- If hospital, additional pre-natal, delivery, and post-partum services are included, an additional $1,100 to $1,300 would be required.*
- Thus a full range of sevices, including delivery would cost up to $3,000 per client.
- Of course, some of these costs would be covered by other programs, such as (a) Medicaid for pre-natal, delivery and post-partum care for adolescents from low-income families, and (b) title XX for day care and other social services.

3. We are convinced that these costs are considerably lower than the costs of not intervening. (See supporting documents section for a listing of some of these costs.)

* Estimated costs to Medicaid for 10 months of pregnancy care, including two post-partum visits is $1,550, of which $350-$400 is for doctor fees and the remainder for hospital charges. However, $200 of this amount is subsumed in the $1,600 mentioned previously.

Table 1

Program Cost Data for Five Comprehensive Service Programs for Pregnant Adolescents

	Program A	Program B	Program C	Program D	Program E
Total budget (FY 77-78)	265,000	503,000	340,000	195,451	290,000
Regular Public School Education	125,000	205,337	-	6,000	72,900
Comprehensive Program Costs (Total budget less Education)	140,000	297,663	340,000	189,451	217,100
Number of Mothers Enrolled	250	400	425	230	260
Average Cost Per Mother	560.00	744.16	800.00	823.70	835.00

Table 2

Services Provided by Five Comprehensive Service Programs for Pregnant Adolescents

Service Provided	Program A	B	C	D	E
A. Educational Services (in addition to public school education)					
1. Special instruction for teenage parents	Yes	Yes	Yes	No	Yes
2. Educational and Vocational counseling	Yes	Yes	Yes	Yes	Yes
B. Medical Services (in addition to routine hospital care)					
1. Prenatal care	No	No	Yes	No	No
2. Health counseling	Yes	Yes	Yes	Yes	Yes
3. Labor and delivery	No	No	Yes	No	No
4. Post partum care	No	No	Yes	No	No
5. Well baby care	No	No	Yes	No	No
C. Social Services					
1. Services to pregnant girls	Yes	Yes	Yes	Yes	Yes
2. Follow-up services for adolescent mothers	Yes	Yes	Yes	Yes	Yes
3. Counseling services to fathers	No	Yes	Yes	Yes	Yes
4. Counseling to parents of adolescent	Yes	Yes	Yes	Yes	Yes
5. Psychological Testing	Yes	No	Yes	No	No
D. Infant Day Care	Yes	Yes	No	No	Yes
E. Meals to Pregnant Adolescents and Mothers	No	Yes	No	No	Yes
F. Transportation for Mothers and Children	No	Yes	No	No	No

Table 3

Estimated Costs For Services in a Comprehensive Program for Pregnant Adolescents, Adolescent Mothers and Fathers, and Babies

Service Provided	Cost Per Adolescent Mother
A. Educational Services (Special instruction for teenage parents, educational and vocational counseling; not including public school education)	$122.00
B. Medical Services (Prenatal care, health counseling, labor and delivery, post-partum care, well baby care; not including routine hospital care associated with labor and delivery)	$200.00
C. Social Services (Services to pregnant girls, follow-up services for adolescent mothers, counseling to fathers, counseling to parents of adolescent, psychological testing)	$454.00
D. Infant Day Care (Assumes 15% of mothers use service)	$228.00
E. Meals to Pregnant Adolescents and Adolescent Mothers	$ 67.00
F. Transportation for Mothers/Children (Assumes 50% of mothers use service)	$101.00
G. Costs Not Chargeable Directly to Client Services (Physical facilities, administrative costs, pregnancy prevention outreach to community, staff training, program evaluation)	$442.00
Total Cost Per Client	$1,614.00

WHY DO WE NEED NEW LEGISLATION

Q. Why do we need new legislation to provide these primary prevention and care services?

A. First, existing HEW programs have a narrow legislatively defined focus. Maternal and Child Health services under title V of the Social Security Act are limited to health services for prospective mothers, children, and infants, and family planning services; Community Health Centers are restricted to providing health services in medically underserved areas; and title X projects concentrate on providing family planning services.

- The recent HEW assessment of Family Planning services to teenagers has given us an indication of how difficult it is for single purpose providers to establish a multiple services network. Even though many family planning providers expressed a need for both medical and non-medical referrals, under 20% of the providers had systematic referral networks. Most referrals were informal and non-systematic and were for pregnancy related health services.

Second, while we could modify existing authorities and program management, such as title X, each program would still have its own specially defined focus and the probability of multiple services and linkages would be enhanced only slightly.

- Funds would still go to those providers who have major target groups to serve, of which adolescent pregnancy is only one. They would still see themselves first as providers of a particular type of service, rather than of multiple services.

Third, new legislation will give local communities the freedom to choose the type of agency (or agencies) they want to have lead responsibility in developing an adolescent pregnancy prevention or care program.

- Some communities may decide that the school system should head up the program, other communities might use a YMCA, while some may ask a planned parenthood or family planning clinic to take the lead. The new legislation would provide local communities with the flexibility necessary to address the problem of adolescent pregnancy in a manner consistent with their priorities and needs.

Finally, for a number of reasons not fully understood, many sexually active adolescents will not go to providers of certain types of services.

- Many do not go to family planning clinics or to health clinics. These adolescents, many of whom probably never use contraception, and who contribute a disproportionate share of pregnancies, need to have alternative facilities.

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WHY A PRIMARY PREVENTION PROGRAM IS NOT SUFFICIENT

Q. Why are we not focusing exclusively on a primary prevention program for teenagers, since primary prevention would make a support program for pregnant adolescents unnecessary?

A. Primary prevention programs are effective for those who use them. A recent national survey indicates that girls who do not use contraceptives are six times more likely to get pregnant than girls who use contraceptives regularly. And we know (from that same survey) that among unmarried teens there has been an increase in the regularity of contraceptive use and the use of more effective methods.

However, there are many teenagers who never use—or only sometimes use—contraception. Ninety percent of premarital teenage pregnancies result from these non and sometimes users.*

To date, research has not provided us with a single answer as to why teenagers do not contracept. However, lack of access was cited by only 30% of non-users as a major reason for not using contraception.** Other reasons cited were: didn't think they could become pregnant, moral or medical objections.

Access and availability of primary prevention does not ensure contraceptive usage. The Service Delivery Assessment of Family Planning Services for Teenagers indicates that about 50% of teens who come to family planning clinics drop out (i.e. do not come back for checkups or prescription refills). Another study* showed that 30% of adolescents who initially use contraception do not continue to do so on a regular basis.

Since no primary prevention program will eliminate all unintended pregnancies, we will continue to need support programs for those adolescents who do become pregnant and choose to carry their pregnancies to term.

*Kantner and Zelnik, Family Planning Perspectives May-June, 1978
**Kantner and Zelnik, Family Planning Perspectives, 1975

Adolescents in Need of Services

PREVENTION

Estimated # of female adolescents at risk.*		4.6 M
Estimated # receiving services from private physicians	1 M	
Estimated # receiving services from organized family planning providers (FY 78)	1.5 M	
Estimated # who will receive services through organized framily planning providers due to FY 79 funding increases.	.3 M	
Estimated # of newly eligible due to CHAP legislation.**	.3 M	
Total # eligible or receiving services	3.2 M	
Number of adolescents in need of services		1.4 M

* All sexually active adolescents (married or unmarried) including those who may be planning for a pregnancy.

** We are unable to project how many of these eligible adolescent may already be using contraception, how many may need services, or how many will use the medicaid services for which they are newly eligible.

SUPPORT SERVICES		1 M
Number of pregnant adolescents		
Number who opt for an induced abortion	315,000	
Number of early spontaneous abortions (prior to 20 wks, therefore requiring minimal medical assistance)	90,000	
Number requiring prenatal care, care due to spontaneous abortion subsequent to 20 wks, delivery, and post-partum services		595,000
Services Available		
Maternal and Infant Care Projects (63,200 delivery only, 68,000 delivery and prenatal)	131,200	
Medicaid*		
Currently eligible	145,000	
Newly eligible (CHAP)	10,000	
Private Insurance**	167,000	
Number with support services available	453,200	
Number without support services available		142,800

* Number estimated eligible for all public and private third party payment is in the process of being verified on a special HEW computer run. Current Medicaid and Chap numbers assume adolescent pregnancies are equally distributed throughout the population.

** Private insurance number from House Select Committee on Population Affairs.

PROJECTS UNDER THE NEW LEGISLATION

Q. What kinds of projects will be funded by the "Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978"?

A. We expect to fund projects which pull together a variety of services in either single-site settings or which are linked through a well integrated network. Projects may be oriented to primary prevention or comprehensive support services for pregnant adolescents or both.

Types of services which could be provided include the following examples:

- o education concerning sexuality and the responsibility of parenting;
- o special education and social services to help keep pregnant adolescents in school;
- o primary health services, to include pre- and post-natal health care;
- o counseling, to include vocational and employment, health, mental health, nutrition, family planning;
- o family planning services; and
- o residential services to pregnant adolescents.

Attached are descriptions of primary prevention and care projects which have been identified* as the types of projects appropriate for funding under the project grant program.

Although not all these projects are fully comprehensive, they do exemplify the kind of diversity and innovation which we are encouraging communities to undertake.

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* Identified by Dr. Nix, the HEW Service Delivery Assessment team (Family Planning Services for Teenagers) and HEW staff site visits.

Anchor Agency: San Bernadino County Health Care Services Agency (San Bernadino, California)

Services Provided: Family planning, counseling, sex education, health care, referral for medical and non-medical needs.

Linkage Mechanisms: Trained social workers provide one on one voluntary counseling sessions within the schools on topic such as family planning, sexuality, drug abuse and social and personal problems. Health and contraceptive services are provided at the health department. Workshops on adolescent sexuality are held for secondary school teachers and the program staff is currently working with the schools to update and revise the school system's sex education curriculum.

* *

Anchor Agency: Norfolk Public Health Department - Norfolk Family Planning Project (Norfolk, Virginia)

Services Provided: Family planning, counseling, sex and health education, referral network for both medical and non-medical needs.

Linkage Mechanisms: Extensive outreach program into the community. Media oriented health and sex education program (utilizing locally produced slide-tape presentations, films and posters) is presented in surrounding colleges, junior and senior high schools, neighborhood centers, boys clubs, hospitals and to students at a medical school. Materials are also used by the TV and radio stations.

* *

Anchor Agency: Mt. Sinai Hospital Family Planning and Teen Services Program (Chicago, Illinois)

Services Provided: Family planning, counseling, and sex education.

Linkage Mechanisms: [illegible]ff work within neighborhood schools to provide a 20 hour six week se[illegible]cation course. Rap sessions on health and sexuality and a separate teen clinic are provided at the local YMCA. An eight week sex educatuion training program is held for professionals and paraprofessionals who work in youth related programs. Parents are invited to attend.

* *

Anchor Agency: Planned Parenthood of Miami Valley (Dayton, Ohio)

Services Provided: Family planning and counseling with an extensive outreach/community education program.

Linkage Mechanisms: Outreach program includes a daily 3 minute public service radio program on sexuality and family planning, parent workshop on teaching your children about sex at home presented at pre-school, day care and head start centers, speaking engagements to civic groups and particularily men's service organizations and workshops for parents and their pre-adolescent children sponsored by a YMCA.

PRIMARY PREVENTION
AND SUPPORT

Anchor Agency: Atlantic City Medical Center, under the Department of Social Services (Atlantic City, New Jersey)

Services Provided: Family Planning, male and female comprehensive health clinic with peer counseling by training Explorer Scouts, VD counseling and care, health services for pregnant adolescents (pregnant teenagers are assigned a single counselor who remains their contact at the hospital regardless of the nature of the problem), sex education programs.

Linkage Mechanisms: Have male outreach worker on the staff, provides sex education when requested by the schools, has worked with parent groups to develop school based sex education curriculum. Primary funding sources are titles V, X, and XX.

* *

Anchor Agency: Onondaga County Health Department (Syracuse, New York)

Services Provided: Family planning, counseling which includes group sessions with trained social worker and one on one counseling, teen health clinic, extensive referral network for health and school problems, health and education program for pregnant adolescents.

Linkage Mechanisms: Primarily linked to other health department programs and school system. School Board provides part of the funding for the pregnant teen program.

SUPPORT FOR PREGNANT ADOLESCENTS

Delaware Adolescent Program, Inc.
State of Delaware

Anchor Agency: Private Corporation with a 15-member Board of Directors

The DAPI program is the only statewide comprehensive program for pregnant adolescents, young fathers, babies and families. Services are provided under one roof with at least one center in each county. The program offers four basic services - education, social services, medical care and infant day care. The Board of Directors is advised by an interdisciplinary Statewide Coordinating Committee which was established by the Governor of the State of Delaware. A State plan was prepared setting forth an operational program for serving adolescents throughout the state which has been used as a guide in establishing programs and developing services.

Specific Services:

Education
Continuation of public school education
Vocational education program, including
Business and Office occupations,
Consumer and Homemaking Education
Special educational programs such as
Child Care and Development,
Drug Use and Abuse, Legal Problems affecting the young mother

Medical Care

Prenatal and postpartum care by program obstetrician's in New Castle County center; monitoring of medical care in other three centers.

Classes in Preparation for Childbirth and Delivery

Family Planning program

Nutrition Classes and Food Program

Social Services

Intensive individual and group counseling
Counseling of families and fathers of babies
One year follow up program for mothers, fathers and babies

Day Care

Infant day care center for babies 1 week to 3-½ years of age
Development assessment of babies
Planned infant curriculum for staff and mothers
Training of mothers in child care and development

Transportation

Girls and babies in rural centers are transported to the center on buses operated by Dapi

Prevention of Pregnancy Program

A grant recently received from the City of Wilmington will enable Dapi to establish a city-wide pregnancy prevention program for non-pregnant adolescents, male and female, and their families.

Services will include outreach programs, development of liason prevention programs with community agencies throughout the city, schools, churches, family planning clinics, etc.

Linkages

Dapi utilizes a $150,000 grant from the Delaware General Assembly to secure over a half million dollars in funding and services from approximately ten local, state and federal agencies. Other services are linked to Dapi through both formal and informal arrangements. Among the agencies are

New Castle County Council
Sussex County Council
Cities of Wilmington and Newark
State Dept. of Public Instruction
State Dept. of Health and Social Services
Local School Districts
Private Foundations

California Programs for School-Age Parents
State of California

Anchor Agency: Special Education Departments of California State Department of Education

Pregnant girls in California who remain in school are assigned to self-contined classrooms. The educational program includes subjects which lead to graduation. Special courses are also taught in order to meet family planning health and medical needs.

California passed SB 1860 in 1974 which provides state funds for school districts to set up infant toddler day care programs near the regular high school campus. Appropriations from the state have grown from $600,000 to $1.2 million since 1974.

Services Provided

Day care for babies of young mothers attending the regular high school

Mothers are required to take a class in Parenting and a Lab in the infant center

Non-parents are required to enroll in the Parenting classes and lab

Linkages

Family Planning Programs
Medical Community
Public Health Department

New Futures School - Albuquerque, New Mexico

Anchor Agency: Albuquerque Public Schools

New Futures School is a comprehensive program for school-age parents offering educational, health and social services to young women and their families. Located in a former public school building, the program also offers day care for young mothers needing the service.

Services Provided:

- Continuation of education — grades 8 through 12
- Special instruction in health care, nutrition, family living
- Counseling of students, families and fathers
- Child Development instruction and laboratory experience
- Creative homemaking
- Health services which include monitoring of adolescent's medical program, hospital visit following birth, instruction in family planning
- Social services to adolescent and her family
- Follow up social services
- Child Care program utilizing students as aides

Linkages

Services and financial support are obtained from various local, state, and federal agencies and organizations

Examples

- Bernalillo County Maternity and Infant Care Project
- New Mexico Health and Social Services Department
- Vocational Education Division — State Department of Education
- YWCA and YMCA

Johns Hopkins Center for School Age Mothers and Their Infants

Anchor Agency: Johns Hopkins Hospital
Baltimore, Md.

The program provides services to pregnant girls and young mothers in the city of Baltimore. Pregnant adolescents entering the program receive continued comprehensive care from the prenatal period through three years after birth, with descreasing frequency and intensity during the third year. The program has strong health and social service orientations and depends upon cooperation of community agencies.

Services provided:

Pregnancy diagnosis
Prenatal care (medical, nutritional, Psycho-Social)
Labor and Delivery Care
Newborn Infant Care
Postpartum Care
Follow-Up services to mother and child (and father) including well baby care, developmental screening, family planning examinations, educational/vocational counseling

Linkages

Some of the services described above are provided by:

Maternal Infant Care Center of the Baltimore City Health Department
Kennedy Foundation
Johns Hopkins University
DHEW, Social Rehabilitation Agency

Laurence Pacquin Jr. Sr. High School
Students attending the school receive regular instruction in an educational program along with supportive services such as social services

Mt Sinai Hospital Family Planning and Teen Services Program

There are three major components of the Mt Sinai Hospital Program.

The Sex Education and Guidance Program provides for a 20 hour six week sex education course which is offered in neighborhood high schools. This past year about 6700 students in 10 high schools were enrolled in this course. An addition 1000 junior high school students (in 12 grammer schools) were enrolled in a similar four week course. This aspect of the program has received support through foundation funding.

The second component - The Sex Education Training Program provides an eight week sex education training course for professionals and para-professionals who work in youth related programs. Over 100 staff persons and parents participated in this program last year. Funding is provided through title I ESEA.

The Youth Education Services Program (YES) is the third component of the Mt Sinai program. A special teen clinic is open one night a week at a local YMCA. This clinic provides family planning services, education, counseling, and referrals for both medical and non-medical problems. A special Rap Session for both male and female teenagers is held in conjunction with the clinic. The rap session are used to convey concrete information about reproduction, contraception, and health as well as to discuss teen feelings about sexuality, responsibility, parent-child conflicts, drug use and any other issues which are of concern to the teenagers. Additionally YES works closely with the total range of YMCA programs and provides special sex education sessions for GED classes, the central Y college programs and is now working with parent groups of the Y sponsored preschool program. YES is funded through title X.

The New Futures Schools is Linked to The Community in the following ways.

The school is a project of the Albuquerque School system and housed in a school system facility. However, there is a also a private, non-profit agency which funds some of the services and serves in an advisory capacity to the school district.

While the school itself provides health education, health monitoring, and nutrituion services it is also linked to a federally funded Maternity and Infant Care Project. A special M&I clinic is held in the New Future School Building once a week and a majority of the girls use this medical facility.

Individual and group counseling is provided for each girl, her boyfriend or husband, and family. When apropriate referrals are made to other social agencies and community services. A counselor often accompanies the girl in making the initial contact for aid.

New Future staff reach out into the community by serving as workshop leaders and speakers for staff training, school classes, and young people groups.

THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF MEDICINE
720 RUTLAND AVENUE
BALTIMORE, MARYLAND 21205

OFFICE OF CONTINUING EDUCATION
TURNER AUDITORIUM BUILDING

CABLE ADDRESS
HOPKINS

May 31, 1978

Lulu Mae Nix, Ed. D.
Coordinator
Adolescent Pregnancy Initiative
Department of Health, Education
and Welfare
Public Health Service
Washington, D. C. 20201

Dear Lulu,

I am sorry that I could not come to your meeting in Washington last week, or the end of the week before. As Denese Shipp may have told you, the roof quite literally fell in.

With the help of various administrative people we have done our best to account for our adolescent program costs. They cannot be meaningfully interpreted without at least a brief description of program objectives and approaches to reducing the medical as well as the social risks which often get adolescents off to a bad start.

I am just completing some research in the child development study and there is no doubt that pregnancy complications, prematurity, illness and malnutrition during early life have a positive affect on later outcome and, as Drillien has shown, when combined with a bad social environment, the long-range effects can be disastrous.

If you have questions please telephone me at (301) 955-5928.

With best personal regards,

Sincerely,

Janet B. Hardy, M. D.
Professor of Pediatrics
Co-Director, Adolescent
Pregnancy Program

JBH:cmk

Attachments

COST ESTIMATES FOR COMPREHENSIVE SERVICES TO TEENAGE PARENTS

PART I - BASIC BUDGET AND ENROLLMENT DATA

1. Total dollars in your 1977-78 fiscal year budget $ 340,000

2. Number of pregnant adolescents enrolled in your program during the 1977-78 fiscal year 425
(Do not include mothers in your follow-up program)
200 mother/child pairs in each of 3 years of follow-up -
75 fathers, 675 individuals per year

3. Please attach a copy of your 1977-78 fiscal year budget showing sources of income.

PLEASE SEE ATTACHED.

Instructions for Parts II and III

For each of the services listed in Part II, estimate the annual costs for 1977-78 that are directly chargeable to these services. Also, estimate the number of clients who received these services in 1977-78. If your program does not provide a service listed in Part II, enter a zero (0) for both the number of clients served and the cost.

Costs that are not directly chargeable to client services (such as building maintenance and custodial services) are listed in Part III of this form and should be reported there.

PART II - COST ESTIMATES FOR SERVICES PROVIDED TO TEENAGE PARENTS AND THEIR CHILDREN

Service Provided	Number of Clients	Cost of Service Costs per Year
A. Educational Services		
1. Regular public school education offered within the comprehensive center (include both academic and vocational programs)	0	$ 0
2. Special instruction for teenage parents (e.g., maternal health and nutrition, child care, family planning, etc.)	900	$ 32,276
3. Educational and vocational counseling	700	$ 5,245
4. Other educational costs	425	$ 3,297
(specify) nutrition - prenatal materials, films, etc.		
Total costs for educational services		$ 47,123
B. Medical Services - in addition to routine hospital care		
1. Prenatal care	425	$ 26,421
2. Health counseling (counseling from nurses regarding preparation for delivery (included in 1 above)		$
3. Labor and delivery - postpartum & neonatal services	425	$ 17,944
4. Post-partum care - i.e., 4 week visit	400	$ 3,886
5. Well baby care (medical care of newborn, immunization, etc.) - 3 year follow-up	500	$ 17,149
6. Other medical services		$
(specify) acute pediatric care for minor illness and telephone consultation included - 5 above)		
Total costs for medical services		$ 65,400

For: (1) Reimbursable hospital costs for routine pregnancy care;
(2) Family Planning Services contributed by Baltimore City Health Department.

(Please see attached document for Johns Hopkins Program).

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Service Provided	Number of Clients	Cost for Service
C. Social Services		
1. Services to pregnant girls (e.g., counseling, home visits, medical personnel, etc.)	425	$ 13,188
2. Follow-up services for adolescent mothers (e.g., counseling, home visits, follow-up on educational progress, family planning, child care development, etc.) - 3 & 4 below are included in 1 & 2 above.	400	$ 6,990
3. Counseling services to fathers	75	$
4. Counseling to parents of the adolescent	# not available	$
5. Psychological testing	425	$ 18,300
6. Other social services (please specify)		$
community outreach	"	$ 19,172
		$
Total costs for social services - includes staff travel and supplies.		$ 63,097
D. Day Care for Children - mothers counselled and referred where needed to existing community resources.	400	$
E. Meals provided to pregnant adolescents and mothers snacks only		$ 500
F. Transportation for mothers/children (bus tokens, occasional taxi fares)	400	$ 3,200
G. Residential care for mothers (foster homes - Florence Crittenton)	0	$ 0
H. Other costs for services not listed above	0	$ 0
(specify)		$

PART III - COSTS NOT DIRECTLY CHARGEABLE TO CLIENT SERVICES

	Cost
1. Physical facilities (building rental, maintenance, custodial services, etc.) Impossible to estimate	$
2. Administrative and secretarial costs (salaries of administrative and secretarial staff, office supplies, etc.) provided by 4 below & by admitting sibs and friends to all educational sessions	$ 55,009
3. Pregnancy prevention outreach to those not in program	$ -
4. Consultation provided to other agencies	$ 11,905
5. Staff training - included in 4 above	$
6. Program evaluation - personnel, supplies and facilities	$ 46,695
7. Other costs not directly chargeable to client services (please specify) _____	$
Total costs not directly chargeable to client services	$

3. Sources of Income - Johns Hopkins Program

Johns Hopkins Hospital - reimbursable costs for prenatal care, labor and delivery, postpartum and neonatal services.

Johns Hopkins University - supervision, administrative services and space - some costs recovered from indirect cost element on grants.

John F. Kennedy, Jr. Foundation - $100,000.

DHEW, Social Rehabilitation Agency, EPSDT Program (matching funds), $240,000.

Baltimore City Health Department - Family Planning Services and supplies.

THE JOHNS HOPKINS CENTER FOR SCHOOL-AGED MOTHERS AND THEIR INFANTS

OBJECTIVES

The objectives of The Johns Hopkins Center for School-Aged Mothers and Their Infants are basically preventive. Seven different approaches are made to reducing the medical, psycho-social and educational risks faced by adolescent mothers and their infants.

(1) The primary objective of the entire program is a healthy mother with a healthy baby and on this essential foundation, to provide the services required to enable both to become productive members of society.

(2). The prevention of early repeated pregnancy (a major risk in adolescents who have already had one pregnancy) and of initial pregnancies in other adolescents are major objectives.

(3) Re-entry or continuation of the mother in school for completion of her education or workstudy program is an essential objective.

(4) Staff training and consultation are provided to enhance the effectiveness of work with adolescents, both at Johns Hopkins and in other communities. There are over 200 visitors - program people, students, nurses, etc. per year who spend one or more days observing and learning about the program.

(5) Development of curricula and educational materials suitable for adolescents, with reference to pregnancy, labor and delivery, family planning, health care, nutrition, toxic substances (drugs, alcohol and cigarettes), V.D., child care, child development and parenting coping and interaction with community agencies. These materials are for our own use and fon export to other community programs.

(6) Through research and evaluation, an attempt is made to improve the efficiency, cost effectiveness and quality of care in terms of overall program effectiveness (reduction in rates of pregnancy complications, low birthweight, infant death, repeat pregnancy, school drop-out and improvement in maternal and child health, child care, and developmental status as compared with similar mothers and babies served elsewhere). The results of these investigations are shared with local agencies concerned with adolescents

and with interested others around the country and by means of scientific publication.

(7) To assist adolescents obtain access to existing community resources for appropriate education, welfare services, day care, and other needed services.

PROGRAM COMPONENTS

The program is designed to meet the objectives outlined above. It is a continued care program, providing comprehensive services from the prenatal period through three years after birth, with decreasing frequency and intensity during the third year. The compopents are designed to meet the needs of adolescents in a way which is acceptable to this age group. The same key staff members provide continuity and linkage of services between the various components of the Hopkins program. Because of the recognized medical and social risks, the Hopkins program has strong health and social service orientations, depending upon excellent cooperation with existing special programs in the Baltimore schools for the education of the mothers.

A major role of the Hopkins program is the linkage of medical services within the Hospital and the Special Adolescent services with those already available in Baltimore, and making them accessible to the young mothers. These community services are provided by the City Departments of Education, Recreation, Social Service and Protective Services, the Baltimore City Health Department and other community agencies such as the Florence Crittenton Home, Catholic Family and Children Services, various church groups, etc.

A stepwise description of the Johns Hopkins Program and some of its linkages, follows.

PREGNANCY DIAGNOSIS

This service is provided by the Maternal Infant Care Center of the Baltimore City Health Department which serves about 1100 adolescents per year. Of these, about 425 (of the youngest and most high risk) are referred to the Johns Hopkins Program. The pregnancy diagnostic service includes complete obstetrical history, physical examination, routine laboratory tests and counselling and referral for needed services. Adolescents are served separately from older women. The cost is borne by the Baltimore City Health Department.

PRENATAL CARE

Because adolescents have special health needs and are poor users of health care when included in a general setting with adult patients, a separate clinic is maintained for them at Johns Hopkins, staffed by persons competent in handling adolescents.

The adolescents make an average of almost 12 prenatal visits. The services rendered to them can be classified as listed below:

(1) Medical - these are reimbursable costs not charges on the program.

(a) routine prenatal medical care with periodic screening to detect maternal and/or fetal abnormalities;

(b) high risk pregnancy diagnosis and care where indicated.

(2) Nutritional

(a) service is provided by the Hospital nutritionist;

(b) nutritional supplements are arranged by the program staff and supplied by WIC.

(3) Psycho-Social - these are provided by the program.

(a) social service screening on a routine basis, involving young mother, father, parents, etc. for purposes of planning for mother and baby. Service is provided as indicated and necessary referrals are made where problems exist (a high proportion of cases). Repeated checks are made as pregnancy proceeds.

(b) psychological screening to determine individual strengths and weaknesses, with more intensive investigation to diagnose problems (educational and/or emotional). Referrals are made for needed services.

(c) educational/vocational screening, counselling and referral for appropriate placement supplements for (b) above. Many of the girls are not attending school at the time of prenatal registration.

(d) educational services - there are 20 educational group sessions provided, on the average, for mother (and anyone she cares to bring, such as the father, her mother, siblings, friends). The curriculum is designed to cover maternal and fetal development, nutrition, sex education, family planning, drugs, alcohol and cigarettes, labor and delivery,

preparation, early child development and parenting. Special attention is given to the birth process to eliminate fear and to enhance cooperation to achieve an optimal outcome for mother and child.

LABOR AND DELIVERY CARE

The objective is to reduce injury to mother and child, thus containing the high medical costs required for complicated deliveries and the prolonged medical care required thereafter.

(a) routine obstetrical services - cost reimbursed.

(b) high risk obstetrical care as required (for about 12%) cost reimbursed.

(c) support services - paid by program. Psychological support and coaching by on-call nurse team known to and trusted by the young mother to reduce requirements for anesthesia and medical intervention.

NEWBORN INFANT

(a) routine pediatric services - reimbursed.

(b) intensive neonatal care - as indicated - reimbursed (about 12%).

(c) supportive services - objective to promote mother/infant bonding and to enhance quality of mothering and care given to baby by mother during the early weeks and to provide needed information about child care. These services are supplied by the on-call nurse immediately after delivery and during the hospital stay and by the pediatric nurse practitioner (PNP), who does the discharge examination of the neonate, at the mother's bedside.

POSTPARTUM

Educational Services - in postpartum care, child care, family planning, etc. are provided by PNP and on-call nurse during hospital stay.

Pediatric Nurse Practitioner Service -- mothers are provided with telephone numbers and call hours and are encouraged to seek advice about problems once they leave the hospital. There are many, mostly minor, health problems during the early weeks, many costly emergency room visits are prevented by telephone advice.

Postpartum Visit (4 weeks after birth)

(a) medical care and family planning services are reimbursed.

(b) well baby examination and counselling by PNP.

(c) educational services - for family planning, child care, etc. provided by the on-call nurses and PNP's.

(d) linkages for continued health care and family planning are arranged. The mother is assisted to plan for needed services. About one-half of the mothers are referred to existing community agencies. The remainder elect to enter the Follow-Up Component of the program. These tend to be the youngest and most high risk mother/child pairs.

(e) educational/vocational counselling and referral.

(f) social service check and referrals as needed for support services and medical assistance certification for mother and child.

FOLLOW-UP

The objectives of the Follow-Up Program are a healthy and socially contributing mother and a healthy infant, with optimal development for both. Immediate objectives are: prevention of early repeat pregnancy, school drop-out, child neglect and abuse.

To facilitate use of needed services, the Follow-Up Program serves both mother and child (and father) at the same visit.

Follow-up visits are routinely made at 2, 4, 6, 9, 12, 15, 18, 24, 30 and 36 months.

Components of Follow-Up Program

For Infant

(a) Well baby care, preventive innoculations, routine pediatric screening. Individual counselling about health care, nutrition, mothering, child development and family planning is provided by the PNP or pediatrician.

Care of minor illness is provided by the PNP under supervision of the pediatrician.

Major diagnostic problems or acute illness are referred for more definitive pediatric care.

The Baltimore City Health Department provides 2 nurses' aides to weigh and measure babies, test urines, hematocrits, draw lead tests, etc. at no cost to the program.

(b) Referral for nutritional supplements - WIC program.

(c) Developmental screening at 12, 24 and 36 months is carried out by a psychologist who provides individual counselling on child development, stimulation and parenting.

For Mother

(a) health supervision every 6 months.

(b) family planning examination every 6 months.

(c) family planning check and supplies every visit.

These services are supplied by the Baltimore City Health Department at no direct cost to the program:

(d) psycho-social evaluation and services are supplied by a trained mental health counselor; there are many emotional problems, the few psychiatric problems are referred to other community resources. Social service referrals are frequently needed and linkages have been established with community agencies.

(e) educational/vocational counselling is carried out. The young mothers are helped to re-enter school or find appropriate placement in workstudy programs and to make the necessary day care arrangements for their baby.

(f) educational sessions - a major component of the program is education, carried out in small group sessions and on an individual basis. Topics covered are: adolescent and child development; health care; nutrition; family planning; safety; parenting; child stimulation; discipline; community resources and how to gain access to them; problem solving and values clarification. A major emphasis is placed on family planning and personal responsibility.

For Both Mother and Infant

Outreach workers are available on a part-time basis to make home visits where needed to help resolve problems pertaining to child neglect, school problems and the like - to help young mothers with inadequate mothering skills.

Community Volunteers

Senior citizens, high school students and other volunteers to help with various aspects of the program at no cost to the program. Local merchants are generous in donating food for snacks and material for crafts, etc.

Community Liaison

The pediatric co-director and the administrators of both Prenatal and Follow-Up components sit on various community agency boards and committees, helping to focus on adolescent needs and problems, working toward development of needed resources while avoiding reduplication of existing services where they are adequate. Baltimore is fortunate in already having many resources. Liaison between them has improved overall efficiency.

THE JOHNS HOPKINS CENTER FOR SCHOOL-AGED MOTHERS AND THEIR INFANTS

PROGRAM COMPONENTS

TYPE OF SERVICE	WHERE PERFORMED	Cost per Patient	Cost per Visit
1. Pregnancy Diagnosis	Baltimore City Health Dept.	$ 84.00	
2. Routine Medical Care	Johns Hopkins Hospital - Staff	hosp. reimburse.	
(a) prenatal care & postpartum visit*	"	209.00	$19.00
(b) labor and delivery*	"		
routine		326.00	
high risk & C. section		524.00	
(c) inpatient postpartum care*	"		
mother: routine		672.00	
mother: C. section (9%)		1,176.00	
infant: routine		242.00	
infant: high risk (12% high risk, incl. 10% premature)		1,094.00	
3. Supportive Medical Services (cost to APP)		Program	
(a) medical - prenatal	Johns Hopkins Hospital	53.00	4.42
(b) labor and delivery, medical supervision and 'on-call' nurses	"	36.00	
(c) postpartum - on-call nurses and PNP	"	35.00	
(d) postpartum visit - PNP, on-call nurse	"	7.76	
(e) medical follow-up (400 babies - 1600 visit/yr) - PNP's and pediatrician	Child Development Center		9.12
(f) family planning supervision (400 mothers - 1600 visit/yr).	"		1.48
4. Medical Family Planning Services & Supplies	Child Development Center	BCHD	58.00/yr.

TYPE OF SERVICE	WHERE PERFORMED	Cost per Patient	Cost per Visit
		Program	
5. Educational Services			
Obstetric Phase (425 deliveries/yr)	Johns Hopkins Hospital		
(a) health education - prenatal & postnatal	"	$51.12	$4.65
(b) nutrition counselling	"	7.68	
(c) vocational/educational counselling	"	12.23	
Follow-Up Phase (400 mother/child pairs - 75 fathers per year).	Child Development Center		
(a) education - health, nutrition, parenting, child care, family planning, etc. (mother & some fathers for 3 years).		31.99	
(b) education/vocational counselling (mother & some fathers for 3 years).		13.11	
6. Social Services			
Obstetric Phase	Johns Hopkins Hospital	30.07	
Follow-Up Phase	Child Development Center	17.43	
7. Psychological Testing	"		
(a) screening	"	14.27	
(b) assessments (150/yr)	"	66.23	
8. Community Outreach			
Obstetric Phase		23.02	
Follow-Up Phase		23.00	
9. Program Administration - overall obstetric and follow-up (425 prenatal patients and 400 mother/child pairs/yr in follow-up).	Child Development Center Johns Hopkins Hospital	63.08	

TYPE OF SERVICE	WHERE PERFORMED	Cost per Patient	Cost per Visit
10. Training and Consultation (for same patient population as above)		$17.25	
11. Maintenance and Overhead			
(a) facilities costs in the Hospital are included in reimbursable costs; in the university space is paid from grant overhead and University funds.			
(b) supplies, educational materials, etc.		10.59	
(c) travel, client, home visitor, professional (for 825 mothers/yr)		4.85	
12. Evaluation - measurement of overall program effectiveness and cost effectiveness of various components (825 mothers, 400 infants)	Child Development Center	38.12	

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Senator CRANSTON. With respect to the waiver authorities that are given to the Secretary in the bill as introduced, subsection 102(e) would permit the Secretary to waive the provision limiting grantees to using no more than 50 percent of the grant to cover the cost of services, as you know, in accordance with criteria to be established in regulations.

What criteria do you intend to specify in regard to using this waiver authority?

Mr. CALIFANO. Well, I think we will have to look at it as we talk to communities. But we wanted flexibility. You might have a situation, for example, in a rural area, where you would not have the entire set of services, or you might have a very limited number of services in a severe section of ghetto poverty, in which we would not want to inhibit getting services in there—the community could not possibly afford to give them; we wanted the flexibility to put them in.

Senator CRANSTON. Would you expect to be pretty sparing in using those waivers?

Mr. CALIFANO. Well, let me put it this way: I expect to be fair and to try and keep my eye on the fact that the objective is to serve these adolescents in trouble.

Senator CRANSTON. And would you reserve that authority to yourself to use the waiver, or would that be delegated?

Mr. CALIFANO. I think in the early phases of the program, I would be likely to reserve the authority to myself, and see how it worked as time went on.

Senator CRANSTON. I want to stress one point. I see the linking of pregnancy prevention programs and prenatal and postnatal care programs for adolescents as very closely related to the functions of the Deputy Assistant Secretary for Population Affairs, as set forth in Public Law 91-572 and reasserted in S. 2522, the legislation that just passed the Senate.

It seems to me that all departmental policies respecting reproductive health, which would include the health of women while pregnant, should be very carefully coordinated. I would expect the Deputy Assistant Secretary for Population Affairs to have a major role in the adolescent pregnancy prevention and health care program.

Could you spell out the role that official would play in the administration of S. 2910?

Mr. CALIFANO. Well, that official would have a significant role. My belief, Senator, is that as we start this program, I believe we should set this up as a separate office reporting directly to the Assistant Secretary for Health. The Deputy Assistant Secretary for Population Affairs reports to the Assistant Secretary for Health, and all of them report to me. And I would expect we would all work very closely on it. As you and some other Senators realize, no organizational structure is set in cement. And I think one of the things I argue very strenuously before the Congress for is flexibility to move organizations around. And as we get this program started, we will see how it ought to be set up. But in the beginning, I think we ought to start it separately.

Senator CRANSTON. When do you plan to have an appointee for that office?

Mr. CALIFANO. For the Deputy Assistant Secretary for Population Affairs?

Senator CRANSTON. Yes.

Mr. CALIFANO. I am in the process of interviewing people for that post right now, this week.

Senator CRANSTON. Beg your pardon?

Mr. CALIFANO. I am interviewing people right now for it. I am down to about three or four candidates.

Senator CRANSTON. Do you expect to have one soon?

Mr. CALIFANO. Oh, yes, I think we are very close.

Senator CRANSTON. I want to explore further, but I will do it in written questions—this reproductive health matter, and the very broad implications and importance of that.

There is another waiver authority, as you know, in section 103(c)(2), permitting the Secretary to waive the requirement for a decreasing amount of Federal support to a particular program, depending upon criteria to be specified in the regs. And, again, I would like to ask, what criteria will you specify in the regs to permit such a waiver?

Mr. CALIFANO. Well, again, I think we would look at the objective of having the local community pick up the tab entirely, or the State or the city, as to give us a measure of the sense of confidence that they have that this program is worthwhile and valuable. Where it was clear that they had that, and for reasons they did not have enough resources to begin to pick up that tab, I would not want the program to die simply because of that. So, we would try to measure those kinds of situations.

Senator CRANSTON. Do you have any estimate of how often you would expect to use that waiver authority?

Mr. CALIFANO. No at this point, Senator.

Senator CRANSTON. Thank you very much. I do have more questions, but my time has expired.

The CHAIRMAN. We are going to stay in California. Senator Hayakawa?

Senator HAYAKAWA. Thank you, Mr. Chairman.

Mr. Chairman, I would like to make a number of general observations about this very, very difficult problem of teenage pregnancy. A number of reasons have been cited, including some by you, Mr. Secretary, about poverty and idleness, and so on, but the relationship between teenage pregnancies and idleness and poverty, and so on, is complex, and I would like to comment on some of these things.

For example, idleness seems to me, in part, the result of the relaxation of standards in academic life; that is, going to school, even in the elementary grades and certainly through high school, used to be a real job of work, involving homework, study, and anxiety about passing examinations, and anxiety about doing well so that you can get your diploma, and so on. And mothers used to say to their children, "Father works for a living, and your work is going to school, and you have got to do well," and the teachers expected this of you, too.

But with the result of changes in education, school has become more and more a form of play, rather than of serious effort. Nowadays, in many, many schools no homework is required, and there is this interesting phenomenon known as social promotion, which means that you pass from the fifth to the sixth, or the sixth to the seventh grade, whether you have mastered the work or not, with the result that all too many high school graduates with diplomas are not yet able to

read and write; they have been the victims of social promotion all along. So, they have had years and years and years of idleness to enjoy, and, of course, one of the important things about idleness is that it gives time for flirtation, and flirtation leads to you know what.

And then, there is the other additional matter of unemployment. Now, unemployment used to mean hardship. In some societies, of course, poverty means having as many children as possible—usually within wedlock, of course—to be certain to have children to support you in your old age, because in those primitive societies, the infant mortality rate is very, very high. But even in a more advanced form of society, poverty, in most of the world's history, has meant a struggle for survival and working hard even at odd jobs at low wages, and this kept you out of trouble.

Many of us, when we went through high school, worked after school at odd jobs as delivery boys and all kinds of chores, and that reduced the time available for flirtation and the consequences of flirtation. But, today, poverty simply means welfare and food stamps and idleness, and therefore sex, and we have created the conditions of ample idleness in which these things can happen. So, the very, very beneficence and affluence of our society have created some of the conditions we speak of.

I understand, of course, the declining age level at which sexual maturity, menarche, comes on in young women. As a matter of fact, I have often argued that from the point of view of sexual maturity, the 16-year-old of 1910 was equivalent to the 14-year-old girl of 1975. The 14-year-old girl of 1975, in other words, is sexually far more mature than the 14-year-old girl of 60 years ago.

Because we are an affluent society with a great deal of social conscience, measures to help unmarried pregnant girls—counseling, prenatal care, nutritional guidance, postnatal care, day care operations within high schools to take care of the babies of the students—these are fairly advanced programs which we find in some California school systems, so that the mothers of these fatherless children can continue high school with minimum damage to their careers. Now, these girls, these pregnant girls, and these girls with little babies, get so much attention from the authorities; they get so much expensive counseling and, as I say, nutritional guidance and medical care and everything else, that they are the envy of all the nonpregnant girls.

Pregnant girls, in other words, are in an extraordinarily enviable position in some school systems in California where they are so very, very well taken care of. And if we increase the rewards, the attractiveness of teenage pregnancy, well, we simply increase teenage pregnancy.

Now, this leads me to these following further considerations: I would like to see statistical comparisons, if they can be made, or they have been made, of birth rates among teenagers going to schools with high academic requirements, as opposed to teenagers going to schools where easy grades and social promotion are the rule. I would also like to see statistical comparisons between birth rates among teenagers with jobs, or after-school and part-time jobs, as compared with birth rates among girls not so employed. But do not forget the minimum wage laws and child labor laws are keeping children unemployed by law; we compel this idleness in many cases, and therefore, we compel them to have time to fill with you know what.

Now, I did not have those opportunities—maybe I am envious. [Laughter.]

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I know about——

The CHAIRMAN. By the way, Sam, will there be a question at the end of this?

Senator HAYAKAWA. I am bringing up a question, yes, indeed; yes, indeed, there shall be.

I know about earlier sexual maturity, as I say, but parenthood in our increasingly complex society—requiring more and more education to get and hold a job, with the result that a high school diploma is expected of most people, and a college diploma is expected of an awful lot of people to get a job at all—requires social maturity for the responsibilities of parenthood at the same time as the biological possibility of parenthood comes at an earlier age, as I say, because of the changing biological status of men and women. So, to a degree unprecedented in world history, we need social maturity for the responsibilities of parenthood, but we are getting parenthood at an earlier, earlier age, long before social maturity sets in.

I am very much concerned with these problems, and they have bothered me for a long time, because I have been an educator; I have had to deal with children. Now, the one thing that I miss in all of this legislation, all the concern, I miss concern with the fathers of these children. They do not seem to have any responsibility in any of this, and what is to prevent, therefore, these young men or these boys from going on to produce, one after the other, out-of-wedlock babies, while cheerfully continuing with their studies, finishing high school, finishing college, leaving behind a whole trail of unmarried mothers and fatherless children to be taken care of by HEW and local agencies.

Is there within this program, or within all the people who are thinking about it, any concern with making the young men involved face some of the responsibilities that they are placing upon society? I see none. I see evidence, on the other hand, of a male-dominated society that wants to let the boys off free, wherever possible, while we cluck, cluck, cluck, over the girls. And, Mr. Chairman, I want to protest this absence of concern with the male parties to this social problem.

[Whereupon, Senator Kennedy assumed the Chair.]

Mr. CALIFANO. Senator, if I may comment on that, I noted in my opening statement—and, indeed, one of the elements we look toward in the innovative aspects of this legislation is to involve the teenage boy in these programs. Second, there is a program called the child support enforcement program which Congress added to the Social Security Act a few years ago. In the years since I have been Secretary of HEW, I have doubled—doubled—the number of fathers that we have identified under that program, that are making payments under that program and fulfilling their responsibility to do that where they have parented these children. I think we have collected almost $1 billion, since I have been Secretary, under that program, which had collected only a couple of hundred million before then. So, I am after that problem; I am very sensitive to that problem, and I think the administration is.

Senator HAYAKAWA. I realize that that concerns married fathers who deserted their children and refused to pay support payments. You are not talking about that program?

Mr. CALIFANO. Yes; I am talking about that program.

Senator HAYAKAWA. That is not the same program.

Mr. CALIFANO. It is not the same program, but you asked if we were doing anything, and I pointed to the one program in which the Congress had passed a law directed at the issue of responsibility for parenthood.

Senator HAYAKAWA. Yes, but when fathers are ordered to make child support payments, usually they are fathers who have been married and have run away and, of course, refuse to meet their responsibilities. That is one kind of problem.

I am talking about the fathers of these unmarried girls, the teenage fathers. Is there any program that goes after them?

Mr. CALIFANO. This program contains, as I said, and I indicated in my opening statement—we intended to direct some of our innovative programs at that. The actual liability of a father for a child is a function of State law, and I would think you would want to leave it there and not have the Federal Government become the arbitor of family life. In those States where an individual is responsible for that child, whether married or not, we would provide assistance under the child support enforcement program to go after that individual.

Senator HAYAKAWA. Well, I have seen no concern whatsoever with this problem of the teenage father. It is one thing to track down the father who promised, under court order, to make child support payments and did not make them. But this is a different problem that I am trying to call attention to.

Thank you very much, Mr. Chairman.

Senator KENNEDY. Of course, I suppose you could use that same argument in terms of the family planning program, as well, or abortions, whether the father should not be paying into that. I have listened with interest, and I do not think there is any insensitivity, either by the Secretary or by those that support it.

The Federal Government, in terms of family planning and supporting those, irrespective of where we end up on abortion, has not made it a requirement; as the Secretary has mentioned, we left those up to the States. Maybe there ought to be some other kind of a mechanism, but the family planning extension went through on the consent calendar of the U.S. Senate last week.

I would have been interested in my good friend and colleague from California raising those same issues on that issue, rather than targeting out this issue here, trying to deal with a particular problem.

I think the point of responsibility upon the male is an important one, and I do not gather from what the Secretary has said here this morning that you are not recognizing the importance of that.

As I understand a very significant part of the parenting aspects of this bill that are included in there, it would also try and bring that special responsibility to young men, as well. Am I not correct?

Mr. CALIFANO. That is correct, Mr. Chairman.

Senator KENNEDY. Senator Hathaway?

Senator HATHAWAY. Thank you, Mr. Chairman. Mr. Chairman, I would like to put an opening statement in the record. I am not going to read it; I just want to put it in the record at this time, if I may.

Senator KENNEDY. Well, if you would like to summarize it——

Senator HATHAWAY. No; it is a little bit too long, and I have some questions.

The Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978, is directed toward meeting a clear and growing need

in our society. I was pleased to join my distinguished colleagues in introducing this measure on April 13, and look forward to participating in further improvements and refinements as it progresses through the legislative process.

Nearly 13 million of the 60 million women in the wo[illegible]ame mothers in 1975 became parents before they became a[illegible]een-age childbearing rates in the United States are th[illegible]hest among industrialized nations, and indeed, higher th[illegible] de-veloped nations. Adolescent childbearing is becom[illegible]ng problem, often involving serious health and socioeconom[illegible]a-tions in the lives of these young mothers, fathers, and ther[illegible]n.

This bill addresses the need of adolescents for information[illegible]-cation to prevent initial and subsequent pregnancies, strives[illegible]st those who are already pregnant with both prenatal and post[illegible]al health care and support services, to help them remain in school, and become productive and contributing members of society. Finally, it provides for education of those who choose to keep their children to assist them in becoming responsible parents.

The bill intends to fulfill these goals by authorizing grants to public and nonprofit private agencies to help communities support and coordinate services and programs relating to pregnancy.

The statistics which underscore the need for increased services are truly alarming.

Of the 21 million teenagers in the United States between the ages of 15 and 19, 11 million—a little more than half—are sexually active. Further, one-fifth of the 8 million 13- and 14-year-old youths in this country are estimated to have had sexual relations.

One million young women aged 15 to 19 and 30,000 girls under 15 become pregnant each year, resulting in over 600,000 births. The out-of-wedlock birth rate has declined among women aged 20 to 24, but has increased among women aged 14 to 19, with the result that for the first time since 1961, the birth rate among single 18- to 19-year-olds is higher than that of 20- to 24-year-olds.

For those teenage parents who marry, studies have shown that divorce or separation are two to three times higher than in marriages of people in their early twenties. The combination of the strains of adolescence itself, family responsibility, and economic instability are often too much for a young marriage to bear.

Teenage mothers do not often have the skills necessary to support themselves, or to compete in the working world. It was found in New York in 1973 that 85 percent of those who became mothers when they were 15- to 17-years-old had not completed high school. Nine out of ten of those who have a child at age 15 or younger never complete high school either, and more than 4 in 10 never get beyond the eighth grade. Female teenage dropouts most often give pregnancy as the reason for leaving school. And although legislation and regulations have confirmed the right of teenage mothers to an education, teachers and counselors often encourage pregnant students to leave school.

Therefore, due primarily to a lack of skills and secondarily to a lack of infant day care centers, teenage mothers are less likely to work and more likely to be on welfare. The younger the mother, the higher the risk of poverty for her family, so just in terms of economics alone, it makes sense to prevent teenage pregnancies.

Beyond these overall educational, social, and economic considerations, we must realize that because very young women are biologically too immature for effective childbearing, there are serious hazards directly related to the health of the mother and to her child. The risk of death in the first year of life is twice as high for babies born to teenage mothers as it is for babies born to mothers in their early twenties. Also twice as high among babies born to teens is the incidence of low birth weight. This is a major cause of infant mortality and birth injuries such as neurological defects which may involve mental retardation.

I am particularly concerned that this legislation be fully responsive to the unique needs and problems of rural, sparsely populated areas in the delivery of comprehensive services. For example, in the State of Maine over 60,000 low-income women of childbearing age are at risk of unintended pregnancies. There are over 18,000 teenaged women estimated to be sexually active and at risk of pregnancy. One of every five births is to a teenaged mother, and nearly one-tenth of all births in Maine are out of wedlock, half of these to teenaged mothers. Many of these individuals reside in outlying areas where there are no available programs or services directed toward meeting their needs. The adverse health, social, and economic consequences mentioned in section 2 of the bill are further aggravated in these areas. These include a higher percentage of pregnancy and childbirth complications, a higher incidence of low birth weight, higher frequency of developmental disabilities, infant mortality, a decreased likelihood that the mother will complete school, and an increased likelihood that an adolescent marriage will end in divorce.

Along with the tragic human costs, the resulting unemployment and increased welfare burden pose a particularly severe burden on these areas already overwhelmed with these problems.

I was therefore pleased to note that section 103 of the bill gives priority to outreach and the need to serve areas where the incidence of low-income families is high and where the availability of pregnancy-related services is low.

At the same time, however, I am concerned about priorities accorded to comprehensive "single site programs" and to those which "will utilize existing programs and facilities such as neighborhood and primary health care centers. * * *" (sec. 103(a) (3) and (4)).

I am concerned that these latter priorities may operate to the detriment of proposals forthcoming from rural areas which are directed toward establishing comprehensive programs where they do not currently exist and which require multiple service delivery sites to assist a widely dispersed population, while taking advantage of a centralized administrative structure.

It is my intention to propose specific amendments directed toward alleviating this concern and assuring that the needs of citizens residing in rural areas are explicitly recognized and given priority.

Not only does the child of a teenage mother have a higher risk of defect or death than a child born to an older mother, but the teenage mother herself is more likely to suffer complications of pregnancy, or death, due to the depletion of nutritional reserves needed for her own growth.

The evidence supporting the need for legislation to prevent unwanted teenage pregnancies is overwhelming. I cannot emphasize

enough our responsibility to recognize this problem, and to provide the help and support which our teenagers need as alternatives to abortion. We must be realistic, and as the "parents" of this Nation, do what must be done to insure the mental, physical, educational, and economic health and well-being of the generations who are now struggling toward adulthood, and toward the ultimate responsibility of our future society.

Mr. Secretary, it is a pleasure to see you. As you know, I am a little bit concerned about the rural impacts of the bill. Section 103 refers to single-site programs, and states that approved programs will utilize existing programs and facilities, such as neighborhood and primary health care centers.

It seems to me that in rural areas where single-site programs are totally unfeasible and where neighborhood health centers are practically unheard of, I am afraid that this phraseology may act to the detriment of getting some money into the rural areas. What is your opinion on that?

Mr. CALIFANO. Senator, as a result of your discussions with me and your letters to me on this subject, we put the waiver in, in large measure, to respond to your concern, that would permit the Secretary to waive those kinds of requirements in rural area situations, as well as other situations. One of the main points of it was to respond to your concern about rural health and the need in rural areas.

Senator HATHAWAY. I take it that the criteria that are listed—103 (a), subsections (1) through (7)—seem to be in the conjunctive, as if all those criteria have to be met. But I take it that that is not the intent, is that correct, Mr. Secretary?

Mr. CALIFANO. That is correct. They are simply some suggested guidelines to set up priorities for those programs that we would fund first. But to the extent that you feel it is necesary to make this absolutely clear, I have no objection to working out some specific language in the provision to make that clear in rural areas.

From many months of experience in working with you, Senator, I know about your concern in rural areas with programs like this, and I would be happy to work with you.

Senator HATHAWAY. Thank you very much. Now, in your statement you made about the bill last April, you mentioned various factors that are applicable to the teenage mothers we are talking about. They drop out of school; they are more prone to divorce; they neglect their children; suffer from chronic unemployment; go on welfare; and may become alcoholics or drug abusers.

As you know, as chairman of the Subcommittee on Alcoholism and Drug Abuse, I am especially concerned about this last problem. I am just wondering what initiatives or plans are directed at those problems, and I do not mean within the scope of this bill, but outside of this bill.

Mr. CALIFANO. Senator, we have in our budget substantial sums for both alcohol and drug abuse. As I recall, I think we have about $175 million for our alcohol programs, and about $275 million for our drug programs. We are also working to prepare a major new initiative in the area of alcoholism, directed at teenagers and at women. I remember well, when I paid my courtesy call on you, when you raised this

issue with me at that time. We will be having some suggestions for you to look at and help us with in the next several months.

Senator HATHAWAY. That is why I voted for your confirmation, because you told me you would do something about that problem. [Laughter.]

Seriously, I am glad that you have taken an interest in it, and I look forward to whatever the administration is going to recommend with respect to that particular age group, because it is a tough age group to deal with, where the problem is probably more severe than it is in almost any other age group, and is on the increase, actually.

Mr. CALIFANO. Later this month in June, we will be working with the institute of medicine, which is having a conference on teenagers and all the problems related to teenage health and related problems, including this one.

Senator HATHAWAY. Fine. Just one final question: Senator Williams mentioned the problem of unemployment among the teenage adolescent group. Are you going to be working with Secretary Marshall with regard to unemployment programs and training programs for this particular age group?

Mr. CALIFANO. Yes, Senator, we are and we have. We have actually reached an agreement via a memorandum of understanding about how to pursue programs under the youth unemployment legislation, and particularly that portion of it that wants to relate to employment in education for high school students. We have signed an agreement, and the Commissioner of Education and the appropriate Assistant Secretary of Labor have been in touch with high school systems around the country.

Senator HATHAWAY. Fine. Thank you very much, Mr. Chairman and Mr. Secretary.

Senator KENNEDY. Senator Riegle?

Senator RIEGLE. Thank you, Mr. Chairman.

Mr. Secretary, I have been listening with great interest this morning, first to your opening comments and then to the various colloquies that have taken place since. I think you have an excellent program here; I think it is cost-effective in dollar terms.

I think, in human terms, what can be accomplished here in terms of a humane response can prevent lifetimes of suffering and heartache.

I strongly support it; I want to see it done. I think it is something that we ought to have undertaken, really, years ago. Having said all that, it seems to me that, at the same time, we are at a rather unique moment in time where there is enormous pressure by taxpayers who feel that government just cannot continue to grow and, in fact, has to start to recede in size.

We had both Senators from California here this morning: California is the scene where there is the greatest activity at the moment with respect to this kind of feeling. I think we all understand it, probably especially so on this committee.

The Human Resources Committee, I think, tends to attract and collect Senators who, by and large, have some of the strongest feelings and interests about human problems. That is why we choose to serve here.

It seems to me that we are endeavoring to launch a program that we feel very strongly about, at the worst possible time. We are trying to launch it in the face of a desire—almost a blind desire—to shrink Government services and cut down on Government spending, whatever the cost and whatever the consequences.

I am wondering if the administration, at the Cabinet level, has yet had the time to start to take account, in a strategic serious way, the collision of these two pressures—a new administration with some humane impulses trying to respond to problems that have been ignored for a long time, versus this desire on the part of a lot of citizens in the country to find a way to pay less for government and to shrink the size of government.

It seems to me that many of the things that the administration has been advocating are affirmative responses that reconcile these two forces. For example, I know the President has proposed a series of changes in the tax laws that are designed to produce more revenue and eliminate some waste.

I know he has brought forth proposals with respect to civil service reform which are designed to make the Federal Government work more efficiently. I know you have been very hard at work in HEW to try to eliminate abuses, in terms of the fraud and waste that are found in any enormous organization, public or private. I know you are making progress in that area. I know it is a tough problem, and I know you inherited a lot of things that need to be changed.

With all of that going on, I am still wondering if you are ready to really sit down and do some soul-searching about spending priorities, and decide that maybe we are not going to be able to afford another $60 million, even if it is for something as important as this, unless we can find some other part of government activity which is also going on that we can take that $60 million from.

Now, I think there are other areas that are prime candidates for where we might look for savings that we could use to finance new initiatives of this sort.

Because of these realities that are upon us—which I think are not just "California" in nature, but encompass initiatives underway in Michigan and in a number of other States—those who have the most humane impulses, and the people in the Cabinet who are directed to the effort of human problems in this country, are probably going to lead the debate within the Cabinet structure to figure out how we can start to make some very hard judgments about where we can shrink part of the budget in order to let another part get larger where we are responding to problems of the kind that we are talking about today.

I realize that is not an easy task within a Cabinet structure, even with a sympathetic President, and particularly if you happen to be the Cabinet officer with an enormous range of activities.

Nevertheless, I am wondering if you can advise us if there is anything yet underway, to give us some reason to believe that the administration can break out of the established pattern of dealing with spending issues one at a time, and recognize and respond to the fact that the ball game has changed radically.

Unless we can get in front of that and work it out in an intelligent fashion so that we can explain to people, chances are that once we get outside this committee and get to the Senate as a whole and the Con-

gress as a whole, we may find that the blind impulse to want to shrink government will kill off the potential for programs like this before we can ever get them started.

I do not think the public, as a whole, wants that. I do not think that serves the public's interest. But it seems to me that unless we can take that new situation and respond to it with a rationale for reconciling these competing feelings, we are likely to see something as important as this bill fail for reasons that really do not bear in any way at all on its basic merits.

I would appreciate it if you could just talk with us about that problem.

Mr. CALIFANO. Senator, I think I might comment on it from a couple of aspects. I think the American people are saying that they want government to be much more efficient than it has been, and they also, I think, are willing to have a case made for a program that is needed. I do not think that the American people are blindly smashing out at programs. I do not think that the American people want a situation in which Johnny cannot read because the school door is closed and there is no school for him to go to. I do not think they want a situation in which people cannot get health care because the hospital is closed, and I do not think they want a situation in which they will not take care of these children.

As Senator Kennedy noted, somehow or other these children that are born of teenagers, legitimately or illegitimately, in or out of wedlock, with whatever diseases or lifelong scars they bear, will be taken care of. I do think that the American people want a school where Johnny is taught to read. I think they want a hospital that provides health care without an incredible amount of waste that would be appalling in any social terms.

I think they want programs, when we say we think we have a way of dealing with the teenage pregnancy problem and helping with it, where we can demonstrate that the programs have a very good chance of working. I think we can make that case, and I will be submitting additional information to do that.

I think, also, since it has come up again, I would just personally comment that I think Proposition 13 has to be put in some focus vis-a-vis a State that had a $4 to $5 billion surplus, vis-a-vis a State that had rejected a similar proposal in terms of its income tax just a couple of years ago, but voted on this proposal because it is property tax, which is a much more regressive tax than an income tax; and vis-a-vis a situation in which the Governor of the State had preached for years about a no-growth world, and the need for no-growth.

Now, I think the most fundamental thing that we have got to do as an administration is get a handle on inflation and get real growth going again. We tend to forget that in the 1960's when most of these social programs that you and Senators Kennedy, Schweiker, Hathaway, and others, fought for came into being, the economy was growing so much in real terms that even the average taxpayer in this country was taking home more real income and taking care of the poor.

I, for one, think that this country is so affluent and so wealthy, in comparison with any other society today or in the history of the world, that we can certainly afford to take care of these teenage girls and boys

and these social problems that HEW is supposed to be directed at dealing with.

I think it is fair for the taxpayers to say to us, "You be more efficient; you squeeze out the waste, the fraud, and the leakage in those programs," and we are trying to do that. But I think that if we can demonstrate that, I believe and hope and pray that this country and its people—I know its people, in their hearts, have enough compassion to take care of those who cannot take care of themselves.

Senator RIEGLE. I appreciate your comments because you and I are on the same side of this issue. I want this to be a constructive search for how we take the next step.

Yesterday, the House of Representatives, as you well know, voted a substantial reduction in the budget for HEW. They did so not by targeting specific line items, but by making a percentage cut, forcing the Department to decide how that is to be applied, within certain limitations.

I think that is an immediate early warning that I think heralds something that is substantially bigger.

I think we are seeing here that many people in the country, because of inflation and because of other problems, have experienced some erosion in their own living standard, or have stood still in the last 2 or 3 years. They have had to make very tough budgeting decisions in their own family budgets. They have had to cut things out or they have had to forego things. Energy is more expensive, and so they have had to spend more money for utility bills, and so forth.

The long and the short of it is that they are, in turn, now saying to government that we have got to shrink the size of what is going on in government. I think that is only half way to the real point, that we may well have to do with less, at least for a time. The question is, what are the most important things that ought to get the emphasis?

Now, we are trying to launch a program that we ought to have been doing for many years and have not been doing. It seems to me we take on the added burden now of trying to do that at a time when there is this desire to shrink the size of government.

I think the only way we are going to accomplish it is to shrink some other part of government, and I think the debate about national spending priorities must be led by the President and the Cabinet, frankly. In other words, I think if we only resort to old arguments that say that this project or that project is warranted on its merits, we are going to lose that argument in today's climate.

I think we have to be smarter than that. We have got to move ahead of the events and be able to say:

> Look, we are going to have to scale certain things down; now let us figure out what the things are that we can actually afford to scale down, and that we ought to scale down in order to finance certain other things.

I think you are probably the Cabinet officer who is in the best position within this administration to lead that kind of initiative. I am talking about getting started with it almost immediately.

I know there are a lot of things competing for attention; what is going on in Africa, energy problems, and what have you. But I think we must immediately decide the manner in which we accommodate for this new mode and this new reality so that the important things are

maintained and responded to and the less important things are put to the back burner.

I would hope that you and the President could find a way to turn this discussion into that kind of an affirmative debate and set a position, so that the country can take and exercise its feeling about wanting to reduce some of these expenses, but to do it in a way that is not going to do great damage to other people.

I do not think the humane and charitable responses of the people of this country are any different than they have ever been. So, I do not think they want the economies forced in those areas in a blind nonthinking fashion.

But, unless we understand what is happening and get ahead of it and help tailor that response, I think that is exactly what could happen. I do not know a clearer case at the moment that this relates to than this program, because here we are trying to launch a program into a tidal wave of feeling that seems to be against any expansion in government.

I think we have the basis for making a rational argument, because in the end it is going to save money. This is an investment that will pay off and will save us vastly more money in social and welfare programs of various kinds. It helps people, and that is what government is for.

So, I would hope that the Cabinet, perhaps with your leadership, could understand that we do not have any time to lose. We have to face proposition 13 in a working context that people can understand so that our best impulses can find a way to reconcile this need to make some economies in government in the areas where it ought to be done.

Mr. CALIFANO. Senator, I agree with what you are saying, and I believe we can, and we will, provide additional information to make the case for the fact that in cold, economic terms, this is a program that will pay off enormous dividends and will, in the long run, save this country lots of money, just the way immunizing children saves this country lots of money, and just the way a whole host of programs in that area do.

As far as the action of the House yesterday, I guess I would note two things. I think it is unfortunate for the House of Representatives to hide behind a blanket 2-percent across-the-board cut in programs, with limitations on the amount to which any individual program can go.

The Appropriations Subcommittee of the House looked at our budget, program by program, and we looked at it program by program. We made the best judgments we could. I think that if they are, indeed, interested in intelligently dealing with the budget or an issue related to the budget, then they ought to take enough time to look at it program by program the way their committee did.

I also note, in terms of the administration making hard decisions and deciding what should go and what should not go, that even with that cut, the budget passed by the House of Representatives yesterday afternoon is higher than the HEW budget that the President and the administration recommended.

It is a difficult problem, as you say, of picking priorities. The use of zero-based budgeting that President Carter has introduced into the Government is designed to deal with exactly this problem.

The recommendation for civil service reform, which can save millions and millions and millions of dollars in personnel costs and in getting better program managers and better analysts in the Government, is another way that we can respond to the feeling of the American people that Government is too fat and lazy and sloppy and careless. There are ample opportunities to do that.

We are, and will be, of course, looking at every one of our programs, now as we are preparing the budget for fiscal 1980. And we will have to look harder than we looked last year; I agree with that. But there is no doubt in my mind, without getting into specific programs, that I would be willing to find the ways to save money in HEW programs in order to put this program in place, because it is hard to think of a more seering or lasting human tragedy, as well as a better economic payoff, than dealing effectively with this teenage pregnancy problem.

Senator RIEGLE. Well, my time is up, and I will conclude only by saying this: I think it is essential in the Cabinet that there be an effort made to develop a strategy for responding to this situation rationally and intelligently. I do not think it can just be left to whoever the faceless people are in OMB who are juggling requests from different Cabinet agencies.

I think the top people in this administration who care about what happens to people are going to have to make some very tough and, I think, near-term judgments about the spending priorities with respect to national strategic priorities in the country. And I think that every day or week that is lost in focusing on the need to do that and, in an affirmative way, get ahead of these feelings that are loose in the country, I think are days that we cannot afford to lose.

Senator KENNEDY. I thank Senator Riegle.

Just one additional comment on this point, Mr. Secretary: The focus of the attention that has been given on the California proposition has been directed to your department and to the programs which, basically, this committee has been most involved in, in terms of education, in terms of health, and in terms of the elderly.

Therefore, this sense, I think, in a rather unique way probably falls upon your shoulders, and obviously the others that have positions of responsibility within the administration and within the Congress.

The focus is not on the Armed Services Committee and on the Joint Chiefs of Staff or on the Secretary of Defense, at least in terms of the way it has been focused and framed. It has been here, whether we like it or we do not like it.

I think the focus is on how we are going to be able to convince the American people that in providing for the infants—the most vulnerable people in our society, which this bill is directed toward, and toward some of the most tragic human experiences that come upon young teenage girls, with all of the impact that it has on their future lives—falls within the parameter that it is justified. I think that is all we are saying on that issue.

You might like to give a response, and then I have two brief questions.

Mr. CALIFANO. Senator, I agree with what you are saying. May I just make one general comment, because I think it is important to what Senator Riegle has raised and what you have raised?

Senator KENNEDY. Sure.

Mr. CALIFANO. I understand that the focus is on HEW and is on these programs. I would like to note that we have taken some very significant steps. One is in the student loan programs. There were never bills sent to students in this country until we looked at those programs and began billing them. They are paying their loans back now at a phenomenal rate; we are beginning to get that money back.

We have reduced the error rates in the supplemental security income for the blind and the disabled, and also in the AFDC programs, as well.

We have combined Medicare and Medicaid under one person in one office, in a desire to try and wring out the leakage in those programs. We have begun these projects to eliminate overpayments and improper payments; project integrity with medicaid, which we are spreading to other programs. We have the first convictions of doctors and pharmacists under the medicaid program for fraud and criminal activities. We have matched welfare roles against payrolls of the Federal Government. We are doing it in the States, and we will do it in the social security role over time. So, we are rooting out those people who are not receiving the benefits they are entitled to receive. It is not possible to do this overnight, as you well know. But we are putting in place systems that will wring out, in my judgment, at least $1 billion of waste, leakage and fraud from the HEW budget in fiscal 1979. I mention that only because I want you to realize and the people here to realize that actions are being taken.

Senator KENNEDY. Do I understand that Dr. Nix is in charge of the program?

Mr. CALIFANO. She is not yet here full time, but she is here with me today, Senator.

Senator KENNEDY. What kind of staff support will she have, and over what period of time?

Mr. CALIFANO. Senator, she and I are now in the process of putting together a staff plan. I will make sure that she has adequate staff to do this job. We will be putting together a staff plan and a budget for the office, and we will put it together very promptly.

Senator KENNEDY. Can you give us some general idea about what the time flow is on that?

Mr. CALIFANO. Well, I would think that within the next 30 days, we will have a plan for the organization of the office, and a proposal, and I would be happy to send it up here if you would like to see it.

Senator KENNEDY. Senator Hathaway.

Senator HATHAWAY. Thank you, Mr. Chairman. I just wanted to ask the Secretary whether, it would it be possible to come up with some specific figures. I realize that they would have to be estimates, but at least they would be specific figures to show that the $60 million invested in this bill is going to save us a certain sum, whatever it comes out to be. We know that so many of these young people go on welfare, or the babies will become recipients, and so forth.

I think that is the only way we are going to sell this program not only to the Congress, but to the American people. They are justifiably upset because they see the guy drive away in the Cadillac with the food stamps and they say: "Well, we are going to cut back on all the Federal spending with respect to welfare programs."

The only way to be able to convince them that this is not a good public policy is to show them that the program is a good investment. I recall somebody from the Veterans Administration testifying several years ago that for the $12 billion we invested in the GI bill after World War II, we got back $100 billion by the year 1968, in just the increased taxes that these veterans were able to pay as a result of getting a better education.

I remember Sarge Shriver, who is at the back of the room, testifying on the Job Corps and saying that for every dropout in high school, it costs us $100,000 over the lifetime of that dropout. This was back in the sixties; it is probably $200,000 today. This was justifying the cost of $8,000 per student, or whatever it was, for these Job Corps centers.

The Job Corps program did not make out very well, but that was not the fault of the figures. I think we need those specifics, rather than just say: "Well, it is going to save us money later on." to show the people of the Congress and of the country, so that they will get behind some of these programs, which they should really be behind.

I think Proposition 13 was just a reaction to what I just mentioned about the welfare recipients; some of them are getting away with a lot of benefits that they should not get. Of course, there are other factors involved in that, but I am afraid that wave is going to sweep the country. And unless we are in a position now to tell the people concrete figures and say: "Look, this is a good investment," we are going to be washed under by that wave, just as I am afraid is going to happen out in California.

Mr. CALIFANO. Senator, we will provide a whole host of figures which will demonstrate that beyond reasonable doubt. I note just one number. We estimate it would cost about $750 per year per adolescent or adolescent and child to provide the comprehensive services in this program. You have 60 percent of those people otherwise on welfare, and to the extent that we take one off welfare, we are saving probably an aver- of $4,000 to $5,000 per year in welfare and food stamp funds. So, just in 1 year, it is a payoff of 6 or 7 to 1.

Senator HATHAWAY. Thank you very much.

Senator KENNEDY. What you are also talking about, as I understand it, is the coordinating function of a lot of voluntary agencies. We are talking about coordinating the existing schools and the churches, community services, local business groups, and others, together. It is very significant.

We are not talking about establishing a new institution on this, but we are talking about using these resources to bring together existing institutions and coordinating in a way that is going to make the difference. So, we are maximizing the effect of voluntarism in this program, and we are maximizing the resources which exist within the community in that, and that has been stressed, and perhaps has not been stressed enough, either in the questions or in the course of this hearing.

You may have just a final comment on that.

Mr. CALIFANO. Mr. Chairman, that is so right on the mark. Indeed, the legislation, as written, would assure that at least one-half the funds under this bill went to precisely that purpose. And the funds that go for services are really designed to go in those areas of the kind that Senator Hathaway is talking about, where there just are not those services. One of the major things we hope to get out of the legislation is the fact that we will pull together all those voluntary and community resources and make them much more effective in treating the whole person.

Senator KENNEDY. If there are no further questions, thank you very much, Mr. Secretary. And I think there will be members who will be submitting questions to you.

[The following material was supplied for the hearing record :]

United States Senate
COMMITTEE ON HUMAN RESOURCES
WASHINGTON, D.C. 20510

July 18, 1978

Honorable Joseph A. Califano, Jr.
Secretary of Health, Education,
and Welfare
Washington, D. C. 20201

Dear Joe,

As I indicated during your appearance before the Human Resources Committee's June 14 hearing on S. 2910, the proposed "Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978", I believe the Deputy Assistant Secretary for Population Affairs (DASPA) must have a major role in the administration and implementation of HEW's adolescent pregnancy initiative.

Incidentally, I'd like to express my enthusiasm for your appointment of Irv Cushner to this position. He is an outstanding individual in the field who, I am confident, will carry out the duties of that office in an exceptional manner.

The press release announcing his appointment states he "would also advise the Assistant Secretary for Health in the development and implementation of programs under the proposed Adolescent Health Services and Pregnancy Prevention Act". I believe that is a promising step towards my view of the role the DASPA should play. However, I am convinced his role should be far more than an advisory one. I can't think of a policy area more directly within the concern of the DASPA than teenage pregnancy. As you indicated in your testimony, the health consequences of pregnancy in the teenage years when a young woman is still physically maturing can have a long-lasting impact on the reproductive health of the woman. S. 2910 proposes to alleviate these consequences through the prenatal and postnatal care programs it would support.

Leaders in the field of obstetrics and gynecology now recognize that care of a woman's reproductive health cannot be limited to health care alone, but that the physician and his or her staff must also address the woman's social and psychological needs. Thus, the organizational structure I suggest would follow the pattern recommended in the medical community.

In my view, the DASPA is the logical individual to develop guidelines that would ensure that these programs will be appropriate for adolescents and will safeguard their reproductive health.

The DASPA is also the logical individual to ensure that existing H.E.W. authorities related to reproductive health, such as maternal and child health, Medicaid, and title X family planning programs, are utilized to the maximum extent by programs developed under S. 2910.

His responsibility for general supervision and overall policy formulation with respect to population research and family planning research gives him the opportunity to ensure that those research programs place appropriate emphasis on reproductive research pertinent to adolescents, as well as on social and behavioral research that will lead to greater understanding of adolescent pregnancy and its consequences for the mother and the child. Indeed, S. 2522, the "Voluntary Family Planning Services, Population Research, and Sudden Infant Death Syndrome Amendments of 1978", as passed by the Senate, and the accompanying Committee report place a special emphasis on the development of contraceptives suitable for adolescents as well as social and behavioral research related to adolescent pregnancy.

Since the entry of the adolescent into the programs supported by S. 2910 would likely be on a pregnancy-related issue and for the most part will be through a reproductive health center such as a family planning clinic, a teenage pregnancy center, or a prenatal clinic, it seems most appropriate that the responsibility for administering the program should be based in the office of the Assistant Secretary for Health, and specifically in the office of the DASPA.

The many facets of the adolescent pregnancy issue call for a coordination of H.E.W. education, child care, and welfare as well as reproductive health programs.

I recognize that Dr. Nix is an outstanding individual with a great deal of experience in dealing with the problems associated with teenage pregnancy. The health, social, and educational services that are essential to the pregnant adolescent and which must be provided for in programs established under the authorities of S. 2910 can be linked to the administration of the program through Dr. Nix, as part of Dr. Cushner's office, by working with other H.E.W. agencies in establishing coordinating mechanisms, just as the reproductive health programs in the communities will establish linkages with social and educational services.

It would seem to me to be a most efficient use of Department resources if Dr. Nix were to coordinate these programs in close

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consultation with an advisory group composed of representatives of the Commissioner of Education, the Assistant Secretary for Human Development, and the Assistant Secretary for Health, and report to the Deputy Assistant Secretary for Population Affairs.

I wanted to bring these thoughts to your attention, Joe, since I believe the direct involvement of the DASPA in the direction of the adolescent pregnancy initiative will be crucial to its success.

I would appreciate your reaction to this suggestion so that we can have the Department's views during discussion of S. 2910 in Committee.

In addition, there are questions I did not ask you during your appearance before the Committee to which I would appreciate your written response. Your response will, of course, be included in the hearing record. These questions are:

1. What criteria does the Department intend to use to distribute the $60 million authorized to be appropriated in S. 2910?

2. Although the incidence of venereal disease among adolescents is extraordinarily high, S. 2910, as introduced, does not specify screening or counseling with respect to venereal disease among the services to be provided or the priorities to be considered. Would the Department favor amending section 103, Priorities, Amounts, and Duration of Grants, and section 104, Requirements for Grant Approval, to specify screening, counseling, and treatment for venereal diseases as among the services to be made available to pregnant teenagers?

With every good wish,

Cordially,

Alan Cranston
Chairman
Subcommittee on Child
and Human Development

cc: Dr. Cushner

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

AUG 23 1978

The Honorable Alan Cranston
Chairman, Subcommittee on Child
and Human Development
Committee on Human Resources
United States Senate
Washington, D.C. 20510

Dear Alan:

Thank you for your letter and your enthusiasm about the appointment of Dr. Irv Cushner as Deputy Assistant Secretary for Population Affairs (DASPA). I, too, am delighted that Dr. Cushner accepted the appointment. He brings to the Office a breadth of experience and interest in the area of reproductive health which is both needed in this Department and, I can assure you, will be fully employed.

I completely agree with you that the DASPA must play a strong and integral role in our adolescent pregnancy initiative. Dr. Cushner also agrees and accepted the position with the understanding that he would be closely involved with that initiative.

I'd like to explain that a number of options were considered in our decision as to where administratively we should locate the adolescent pregnancy program. Placing it under the DASPA was certainly one of the logical choices. However, with the advice of a number of people both within and outside the Department, I elected at least at the outset to place it as a freestanding initiative reporting directly to the Assistant Secretary for Health (ASH). Making that decision was quite difficult because I think it is important that the Department administratively signal that the location of the Office in ASH does not indicate an exclusive or even primary health emphasis. My major concern was in ensuring Departmentwide coordination in the administration of this program. Development of program policies, the grant review process, and program and project evaluation must involve the substantive participation of the Office of the Assistant Secretary for Human Development Services and the Education Division of the Department. I believe that this can be best accomplished, at least initially, by an individual coordinator reporting directly to the Assistant Secretary for Health.

I think it is important to maintain the flexibility to alter the decision over the longer run, and I appreciate your counsel in this area.

Your letter also raises two specific questions about the legislation. With regard to the criteria the Department intends to use to distribute the $60 million authorized to be appropriated in S. 2910, Section 103(a) of the legislation sets forth these priorities:

- High incidence of adolescent pregnancy;
- High level of poverty with low level of pregnancy related services (including prevention);
- Ability to develop a comprehensive service delivery system;
- Utilization of existing programs as an operations base;
- Maximum use of other funding sources;
- Degree of widespread community commitment to the project as indicated through non-federal share and involvement in planning and implementation.

Projects will be ranked according to how well they meet these priorities.

The Department favors adding venereal disease screening, counseling and treatment as one of the possible services to be provided to teenagers. The legislation as written does not directly exclude these services and we assume that the wording of the legislation in Section 102(b) would allow such services. We are concerned that there not be confusion since, as you know, we view appropriate venereal disease screening, counseling and treatment referral as an essential component of family planning and primary and preventive health services. If you believe it is necessary to be more explicit in the bill, we would favor permissive language. Since we have not suggested mandating any set of services, we would not favor a strict requirement that all grantees must provide VD-related services.

I appreciate your taking the time to bring these concerns and questions to my attention. I would be grateful for your support in assuring enactment of this legislation.

Sincerely,

Joseph A. Califano, Jr.

ECONOMIC COSTS OF COMMON COMPLICATIONS OF ADOLESCENT CHILDBEARING

The chances are disproportionately great that a baby born to a teenage mother will be low-weight at birth. Toxemia and anemia are frequently associated with low birth weight infants, especially those born to adolescents. More than one-third of the 57,000 low birth weight babies born to teenagers each year require intensive care. This care costs roughly $600 per day for an average stay of about 13 days. For the 21,000 babies requiring this care in 1976, the total cost exceeded $163 million.

PREMATURE BABIES' CARE FOUND TO COST $90,000

EVANSTON, Ill., June 15 (AP)—The average cost of saving the lives of extremely small premature babies was found to be $90,000 in a study of 75 of the infants in a Los Angeles medical center.

In one case, the cost was $125,000.

A tem headed by Dr. Jeffrey Pomerance studied the hospital cost, not including doctors' fees, of caring for 75 infants weighing less than 2.2 pounds who were born from January 1973 to June 1975 at Cedars-Mount Sinai Medical Center in Los Angeles.

The results of the study appear in the June issue of Pediatrics, which is published by the American Academy of Pediatrics.

Forty percent of the 75 infants lived, and 80 percent of the survivors tested at 1 to 3 years of age appeared to have developed normally.

Dr. Pomerance and his colleagues said that in evaluating the success or failure of medical care, the cost of care would have to be evaluated eventually.

"We no longer have the luxury of supporting the attitude that no cost is too great," they said. "The day is not far off when we must choose how to spend our limited dollars, and we must make an enlightened choice."

Cost of Living for Infants Weighing 1,000 Grams or Less at Birth

Jeffrey J. Pomerance, M.D., M.P.H., Christinia T. Ukrainski, M.D., Tara Ukra, Diane H. Henderson, M.D., Andrea H. Nash, M.D., and Janet L. Meredith, R.N., B.S.

From the Department of Pediatrics, Cedars-Sinai Medical Center and University of California at Los Angeles

ABSTRACT. This article reports the in-hospital cost of caring for 75 infants weighing 1,000 gm or less at birth who were born during the 2½-year period between January 1973 and June 1975. Thirty infants (40%) survived. Nineteen of 27 infants tested (70%) appear to be neurologically and developmentally "normal" at 1 to 3 years of age.

Hospital charges were adjusted to September 1976 rates and corrected for a 94% collection rate. Physicians' fees represented less than 5% of the total bill and were not included. The average adjusted daily and total costs for the 45 infants who died were $825 and $14,236, respectively. The average adjusted daily and total costs for the 30 survivors were $430 and $40,287, respectively. The average adjusted total cost per "normal" survivor was $88,058. It is our belief that the outcome justifies this expense. Society, however, must be the ultimate judge. *Pediatrics* 61:908-910, 1978, *prematurity, in-hospital costs.*

Less than 15 years ago, infants weighing 1,000 gm or less at birth had only a 10% survival rate,[1] survivors only rarely escaping the sequelae of physical and/or mental handicap.[2,3] Since that time, advances in perinatal diagnosis and therapy have allowed even the very smallest of infants to partake in the generally rising trend in neonatal survival.[4] Even more important, these tiny infants have an improved prognosis for normal function.[5]

In evaluating the success or failure of any approach to medical care, it is important to evaluate not only the outcome of a given regimen but the cost of that care as well. We no longer have the luxury of supporting the attitude that "no cost is too great." The day is not far off when we must choose how to spend our limited dollars, and we must make an enlightened choice. This article reports the in-hospital "cost of living" at our institution for infants weighing 1,000 gm or less at birth.

MATERIALS AND METHODS

Between January 1, 1973, and June 30, 1975, a total of 75 infants weighing 1,000 gm or less at birth were admitted to the Neonatal Intensive Care Unit at Cedars-Sinai Medical Center in Los Angeles. Thirty-four (45%) were born at the center and 41 (55%) were transported from outlying hospitals. Birth weights ranged from 520 to 1,000 gm. Gestational ages ranged from 24 to 32 completed weeks.

Twenty-four of the 30 surviving infants had complete neurological and Gesell[6] developmental evaluations. One infant left before the entire Gesell evaluation was completed. Sufficient information was obtained, however, to approximate the developmental quotient accurately. Two infants were evaluated by qualified professionals other than the authors. The parents of three infants refused to have their infants examined. Infants were evaluated at 12 months to 3 years of postnatal age. Developmental assessments on infants who were 2 years of age or less were corrected for prematurity. Neither the neurologist (A.N.) nor the developmentologist (D.H.) who evaluated these infants was involved in the infant's neonatal care.

Records of hospital charges were available for 59 of 75 infants. These were adjusted to September 1976 rates by applying correction factors to each of the following categories: daily room rates, ventilator and oxygen, blood gas analysis, pharmacy (which included intravenous solutions, hyperalimentation, and medications),

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ADDRESS FOR REPRINTS: (J.J.P.) Cedars-Sinai Medical Center, Los Angeles, CA 90048.

laboratory (excluding blood gas analysis), central supply, radiology, and miscellaneous. Physicians' fees represented less than 5% of the total bill and were not included. Ninety-four percent of hospital charges was collected. Therefore, 94% of hospital charges was used as the actual cost of care. Charges on the 16 patients whose records of hospital billings were not available were approximated by applying the average daily cost (using the appropriate figure for surviving and nonsurviving infants) and multiplying it by the length of hospitalization measured in days.

RESULTS

Survival

Six of 26 infants (23%) weighing 750 gm or less at birth and 24 of 49 infants (49%) weighing 751 to 1,000 gm at birth survived. Overall, 30 of 75 infants (40%) survived, their birth weights ranging between 620 and 1,000 gm and their gestational ages between 25 and 32 completed weeks.

Developmental-Neurological Outcome

Group 1. Four infants (15%) had developmental quotients of 40 or less. One had grade V retrolental fibroplasia and was entirely blind. All were classified as moderately to severely abnormal according to neurological examinations.

Group 2. Four infants (15%) had developmental quotients between 41 and 79. All had moderately to severely abnormal results on neurological examination.

Group 3. Nineteen infants (70%) had developmental quotients between 80 and 114. Fourteen had entirely normal results on neurological examination. Five demonstrated very mild unilateral weakness as their only neurological abnormality. The prognosis for normal function in these infants was believed to be nearly as good as that of the infants who had entirely normal results on neurological examination.

Five infants in groups 2 and 3 had stage I to II retrolental fibroplasia which subsequently resolved completely.

COST OF LIVING

Nonsurvivors

The average length of survival for the 45 infants who died was 17 days, with a range of 1 to 165 days. The average adjusted daily cost was $825. The average adjusted total cost was $14,236 per nonsurvivor. The charges ranged from $72 to $124,627.

Survivors

The average length of hospitalization for the 30 surviving infants was 89 days, with a range of 51 to 194 days. The average adjusted daily cost was $450. As the condition of these infants improved, they were transferred first to the intermediate care unit and later to the continuing care unit, whereas infants who died remained in the intensive care unit throughout their lives. Consequently, the average daily cost for survivors was less than that for nonsurvivors. The average adjusted total cost was $40,287 per survivor. The charges ranged from $10,744 to $106,050.

Overall Cost

The total adjusted cost for the 45 nonsurviving infants was $640,634. The total adjusted cost for the 30 surviving infants was $1,208,582. The overall total adjusted cost for both groups was $1,849,216.

The percentage breakdown of the total charges for the 75 infants is as follows: room charges, 43%; ventilator and oxygen support, 19%; blood gases, 11%; pharmacy, 9%; laboratory, 8%; central supply, 5%; radiology, 4%; miscellaneous, 1%. Fully 30% of the total charges was for support and management of ventilation and oxygenation. (Charges are adjusted to September 1976 rates.)

If the total adjusted cost for the 30 survivors alone is used to calculate the cost per survivor, the result is $40,287. This figure greatly underestimates the true cost, because care provided to infants who die must surely be included in any calculations of cost per survivor. When the total adjusted cost for all 75 infants is used to calculate cost per survivor, then the figure becomes $81,641 per survivor. Survival, however, should not be taken as the sole measure of success. A much more meaningful definition would include evaluations of the infant's potential to become a normal, productive member of society. In our developmental/neurological follow-up evaluations, 19 of 27 infants (70%) were apparently functioning normally. If we assume that the three infants whose parents did not permit them to be examined had approximately the same developmental quotient distribution as the other 27 infants who were examined, then the figure of 21 infants (19 of 27 infants examined plus 2 of 3 not examined) may be used as the most realistic denominator to equate cost per "normal" survivor. This figure is $88,058.

DISCUSSION

Currently, follow-up evaluation of the surviving infants has been of short duration. It is possible that in the years to come, more or less than 70% of the infants may function normally.

Also, subtle abnormalities may become apparent with time. Short-term follow-up does provide, however, a general evaluation of recent care provided and as such provides important feedback to providers of this care.

It is impossible to quantify accurately the enormous emotional costs and benefits engendered by efforts spent in these infants' behalf. Nonetheless, it is part of the human condition that we do include these costs and benefits in any final balance sheet. It is our belief that the cost of living for infants weighing 1,000 gm or less at birth is justifiable. Society, however, must be the ultimate judge, for society must pay the bill and reap the benefits and the heartaches as well.

ADDENDUM

As of November 1977, charges for neonatal services at Cedars-Sinai Medical Center have risen a weighted total (as described in text) of 31% since September 1976.

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Senator KENNEDY. The next witness is Mrs. Eunice Shriver. We are glad to have you back, Mrs. Shriver. Mrs. Shriver testified on this legislation some 3 years ago. She has been, I think I can say without fear of contradiction, the spearhead in this whole concept. She has given a great deal of thought and attention to this issue and has followed the issue very closely.

We are glad to have your views here. I will say all of that with a straight face, too. [Laughter.]

STATEMENT OF EUNICE KENNEDY SHRIVER, EXECUTIVE VICE PRESIDENT, JOSEPH P. KENNEDY, JR., FOUNDATION

Mrs. SHRIVER. Thank you, Senator Kennedy. I am very grateful for this chance to appear before you and to testify in support of the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978.

First, I would like to thank the members of this committee for focusing the attention of the Nation on this compelling problem of teenage pregnancy. Until your interest became a matter of public record, this was an issue with very little prestige. There was no organized lobby, no funding, and only a handful of small organizations fighting on behalf of teenage mothers and fathers and their babies. Now you have given an entire new dimension to this age-old problem which has been faced by every society since the beginning of human history.

I would also like to thank the aides of every Senator on this committee for the time and effort they have spent on this legislation. I have found them open to new ideas, eager to learn, and committed to pursuing the facts of the issues, free of prejudice and in good faith.

As a committee, your responsibility is the protection of the country's human resources. This legislation is aimed at the preservation of our most vital human resource, the family. The birth of a child is still the most important, moving, far-reaching event that we all share. The creation of a secure family in which the child is raised to maturity is still the most enobling human experience.

For more than 25 years, I have worked with teenage girls and I have been concerned with the complex causes, and often tragic outcomes, of teenage pregnancy. This personal experience has been reinforced by the work of the Kennedy Foundation, which has supported several major programs to help teenage girls to have normal, healthy babies and to resolve their deep problems.

I have some additional remarks here, but because time is running out, I would like to have them passed out to the members of the committee. I would like to have them inserted in the record.

I would just like to make two or three short remarks, and then turn it over to some of the specialists who can answer, I think, the very correct concerns that many of you have.

First of all, I think what we are trying to do here in this program proposed in the bill—S. 2910—is to cause a whole revolutionary change in the outlook on family life in this country. We are trying to interest young people in a new kind of concept of themselves—to respect themselves, to respect their parents and grandparents, to respect the child that they will bear, and to respect their community obligations.

I think the program accomplishes this purpose. For instance, a program such as the one at Johns Hopkins provides all of the services a teenage mother needs. When a girl goes to the Johns Hopkins teenage pregnancy program and gets advice on nutrition and is told that when she does not smoke and when she does not take drugs, she will have a healthy baby, she obeys those kinds of advice and instruction and she develops a very profound sense of responsibility to another life, that of her baby.

I think, therefore, that we are starting a trend of greater responsibility at a very early age. The young people in the program are beginning to know and understand what it means to have a family, and to delay pregnancy so that they can give the best to their family. This concept of responsibility is very important.

I was glad, Senator, that you asked the question about girls who do not have pregnancies. I think we should give a great deal more recognition to these girls; you are quite right about that. But I also think, like in medicine, that when you have the most severely alienated group in society or when you have the sickest person in a hospital, you should give the most money and the most care to them.

Among the teenage girls who are pregnant you have really the most alienated young people that there are in society. They are alienated from their schools; they are mostly dropouts. They are alienated from hospitals; they have never gotten good medical care. They are alienated from their families. They have no job skills.

So, these teenage girls are in a very difficult predicament. Unless we make a decision that these conditions have to be turned around, I think we are going to have the continuation of all the problems that you have heard this morning—in terms of welfare, in terms of child abuse, and in terms of injured babies born.

As was pointed out, these young girls have a higher rate of premature babies. That is one of the reasons for teenage pregnancy programs, because we know that millions of dollars can be saved if we can cut down on prematurity; and we all know that. And if we cut down on mental retardation and birth defects in babies born to teenage mothers, then, of course, we will have babies that can grow up and make a contribution to society.

So, I think the important thing for us to understand is that these young girls have to be approached with a whole new, different approach, and it has to be comprehensive. They do not feel that people care about them. We have to make them feel that we do care.

But let us understand what we are basically trying to do here. We are not just going to cut down and save a lot of money, and we will. We are not just trying to get them back to school, and we will. We are not just trying to get them into jobs, and we will. We are trying to encourage them to respect themselves and to understand their obligations to society.

In the program, for instance, over at Johns Hopkins, where the girls receive a whole lot of different services which Dr. Hardy will tell you about, one of the things that I think is most important to understand is that the girls have a program to get into when they first arrive at the hospital and stay in until they leave 2½ years later.

In courses, which are part of the programs, they discuss many different issues, for instance, equality of treatment. Instructors talk about

equality of treatment and other ethical concepts with these girls and say: "If you have a second baby, who pays for that—the community—is that fair?" Some girls may reply: "It is my business; I can have as many babies as I want."

The instructor may point out: "Yes, but who takes care of them? How many thousands of dollars of taxes are paid? Is that equal; is that fair; is that just?" Those kinds of concepts are part of the discussions that the girls are involved in at the Johns Hopkins program.

So, I think those are the kind of larger concepts that we are trying to get across. It is more than just saying: "You go out into the world and do as you like, and maybe this pill will prevent you from getting pregnant, or maybe it will not." You will hear more about why the one-shot approach does not work from some of the experts here today.

We are trying in teenage pregnancy programs a much broader approach. I think in the final analysis, although these teenage pregnancy programs are very successful in terms of secondary prevention, many of you are interested in primary prevention. Senator Cranston raised a number of questions on that.

I think because so many of the young people are alienated, we have to develop a real community approach—as Senator Kennedy was saying—in which families very vitally participate in any kind of approach that is made to these girls in terms of trying to have them delay pregnancy.

In the community approach you have to have doctors; you have to have nurses; and, as I say, you have to have parents. The community will supply nutrition assistance; it will supply education; it will supply discussions of values which, as I mentioned at the beginning, we have found these teenagers have, universally. They may not be your values and they may not be my values, but they have very strong values of their own.

If you say to a teenager: "What do you want most?" They say exactly what I say—and which politicians seem to forget all across the world—that what they want is a healthy baby. Politicians all over the world seem to forget this. Teenagers want a baby that can do well in school, and they even want a baby, interestingly enough, that is athletic.

If you talk to women all over the world, that is what they will tell you. They will not talk about great security; they will talk about wanting a healthy, well baby. So, I think that is what this teenager pregnancy program is all about.

I do not really think there is very much more to add. I think one of the models, Senator, so that it does not sound too vague, for these teenage pregnancy programs is Head Start. For Head Start parents are required to be on the governing boards. Parents are invited, also, to be teachers in Head Start. Parents take the children out in the community and they have all sorts of actual relationships with the children.

I think the most effective instructor in the program at Johns Hopkins is a young lady who had a baby, and you will hear her testify later, without any intervention, without any help. You will hear what she went through. Now as an instructor she can reach these young girls far more easily than almost anybody can.

So, we can reach out to the young girls in their area, in their community, and on their level, and not be imposing rules from the top.

Senator KENNEDY. I have one question, and I know you have got others here who can get into the particular details. I am particularly interested in the concept of parenting, and what you include in that concept and why it is so important in terms of the well-being and health of the tenage girl and the infant, and in terms of avoiding the pregnancy in the future.

I understand that that is sort of a central, common theme which has run through these centers, whether it has been in the Delaware center or in Baltimore, or others. That is a very important kind of concept, besides all the other supportive facilities.

I am just wondering if you might be able to elaborate on what you include in that concept of parenting and why you believe that that has made such a difference in terms of their lives, and why that concept may be different from other types of informational types of activities.

Mrs. SHRIVER. I think that is a good point that you bring out. The environment in which these young girls are getting this kind of assistance is important, because it is a back and forth kind of a relationship, rather than a straight, dictatorial one that you might find in a school.

But let me just say very briefly that the parenting curriculum for the pregnant girl is different from one in a high school. The pregnant girl gets, obviously, all the information that is needed on prenatal care; why it is important to have proper nutrition; why it is important not to do certain kinds of things that would injure the baby.

The pregnant girl gets a good deal of education about the actual delivery of the baby, and then gets a good deal of help in the 2- or 3-year followup period. The followup period is very important to fund because, previously, the young girls have been left alone with their babies 6 weeks after the birth, and that is obviously a disaster.

The pregnant girl gets to hear about drugs and about the importance of bonding between a mother and a baby, which is extremely important in terms of the growth of the child in later years.

The pregnant girl gets to learn about how an infant develops. It seems to me that "How an infant develops" should be an essential course in high school today. It would probably be the most interesting.

Pediatricians, after all, spend 3 or 4 years learning how an infant develops. At the Johns Hopkins Center, the girls receive a very practical course—week-by-week discussions on how their baby within them develops and how their baby develops afterwards, so that they are much better able to take care of it. Then, of course, they hear about immunization, the health of the baby, et cetera.

We are working, Senator Kennedy, on such a course, along with Dr. Coles. Dr. Coles, I might add, made the point to me that the many books on education for parenting that he has looked at, he has found practically nothing on how to involve young men.

I will send you an outline of the course, Senator Kennedy. The outline is clear.

Senator KENNEDY. Are there any other questions?

[No response.]

Mrs. SHRIVER. I think it is rather interesting to look at the headline this morning, which I saw coming down. It says, "House votes slash

of $800 million for Labor and HEW." And then, on the bottom of the page, it says, "$170 million GPO building proposed for District wins Carter support."

And then, it says, "The proposed GPO building is expected to be the most expensive Government building ever constructed." Thank you.

Senator KENNEDY. You are going to leave on that note. [Laughter.] Thank you very much, Eunice.

[The prepared statement of Mrs. Shriver follows:]

Statement By

EUNICE KENNEDY SHRIVER

HEARINGS BEFORE THE SENATE COMMITTEE ON HUMAN RESOURCES

On

THE ADOLESCENT HEALTH, SERVICES, AND
PREGNANCY PREVENTION AND CARE ACT OF 1978

I am grateful for this chance to appear before you and to testify in support of The Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978 (S. 2910).

But first I would like to thank the members of this committee for focusing concern on the issues of teenage pregnancy and for bringing these issues to the attention of the nation.

As a Committee, your responsibility is the protection of our country's human resources. This legislation is aimed at the preservation of our most vital human resource--the family.

For the birth of a child is still the most important, moving far-reaching event that we share. And the creation of a secure family in which this child is raised to maturity is still our most enpobling human experience.

I was happy to accept your invitation to appear as a witness for several reasons:

First, the Joseph P. Kennedy, Jr. Foundation has been working on teenage pregnancy and related matters for many years. For example, the Foundation has:

-- Sponsored and supported work by Professor Lawrence Kohlberg at Harvard University on value systems of young people and how to develop in these young people a better understanding of moral values such as responsibility, fairness, justice, etc.

-- Helped the St. Joseph's Vocational Center in St. Louis and its Director, Monsignor Elmer Behrman, develop a "Life Living Curriculum" for mentally retarded teenagers.

-- Established four years ago at the Johns Hopkins University School of Medicine a model Center for Teenage Mothers and Their Infants. The Foundation's grants have enabled the center to assist annually up to 400 teenage mothers, their babies and fathers as well. Through its support of an evaluation component, the Foundation has made available to everyone some of the best outcome data which exist on the effects of intervetion through comprehensive services.

Second, the Kennedy Foundation has for over 20 years been involved in the important area of early childhood intervention. Its work with Dr. Susan Gray, at The John F. Kennedy Center for Research on Education and Human Development at Peabody College in Nashville, Tennessee, and others provided the basis for the successful "Headstart" program.

Third, I personally worked with teenage mothers at the House of the Good Shepard in Chicago and at the Alderson Federal Penitentiary for Women in West Virginia. I learned through these experiences a great deal about the problems teenage mothers face and their inability to cope with them without caring assistance.

Fourth, the Kennedy Foundation and I are working now to develop a "Family Life Curriculum" which would be valuable in teenage

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pregnancy programs to help the young men and women involved to understand basic moral values and clarify their own thinking regarding those values which form the basis for our society. The group developing the curriculum is headed by Professor Peter Bertocci, an eminent philosopher, who, incidentally, is an Episcopalian.

I am delighted that this legislation is before your Committee, for out of this legislation will come significant long-range benefits to the American family: healthier babies; more secure, better prepared parents. This legislation will support the programs through which values are taught, health is protected, guidance is given and better choices are encouraged.

These programs help adolescents to be better parents without encouraging more to become parents. They are more than simply a health delivery system. They are truly a life support effort on behalf of young parents and their children.

Others will speak from their personal experience about specific teenage pregnancy programs, including the model program at Johns Hopkins. I do not want to take your time to describe how and why comprehensive teenage pregnancy programs work. I do wish to tell you briefly what we have learned about approaches that do not work.

1. One-shot prevention programs do not work. The young people involved in them are usually alienated from society and unable to cope without caring assistance over a long period of time.

2. Programs designed for older women do not work for teenagers. A specialized approach is needed since the young women involved often

have confused goals, are doing poorly in school, have few marketable skills, and have other problems not connected with their pregnancy.

3. Programs which deal with pregnancy as a communicable disease--like whooping cough, typhoid fever, or malaria--do not work. Pregnancy among these young people is an emotional, social and spiritual crisis for the mother, the father, and the parents. Consequently, it requires a community effort to deal effectively with it.

I know that the Committee is concerned with preventing too-early pregnancies. So am I. As Americans, we are always searching for "one-stop solutions to our problems." In this case, a magic bullet which will put an end to teenage pregnancies before they begin. The emphasis on prevention in every health field from drug abuse to obesity is both practical and admirable. But in the case of teenage pregnancies--to shift all our emphasis to prevention-- is to ignore the realities of human experience.

Two Johns Hopkins scientists (Professor Melvin Zelnik and John F. Kantner) have recently completed a study of the relationship between sexual behavior, contraception and pregnancy in American adolescents. They compared two groups of girls, one interviewed in 1971 and the other within the past two years. They concluded that even if contraceptives were used consistently by all teenage girls, there would still be about 500,000 pregnancies each year in this most vulnerable, immature and ill-prepared group. And from these pregnancies we know from past experience that at least 300,000 babies would be born. It is upon these babies and these adolescent parents that part of our attention

But I think we can go further. You will recall that before "Headstart" was enacted, few, if any, communities focused their attention or resources on early childhood development. Yet the preschool years are absolutely crucial to our physical, emotional and intellectual growth. Through "Headstart" the total community made a commitment to the needs of very small children. Not just schools. Not just churches. Not just doctors or even parents. Everyone had a part to play in "Headstart." And because of this involvement, preschool programs are now high on our national agenda.

Through the programs provided in this legislation, the same kind of community commitment can be generated. Calling upon its parents, health professionals, ministers, educators, social workers and ethicists, each community can create a supportive environment in which the pressures and tensions which so often lead to too-early pregnancies are greatly minimized. With your help the consciousness and conscience of America can be raised concerning the moral, emotional and psychological needs of teenagers. Only when this happens will teenagers themselves be able to understand and practice those values of respect, responsibility and concern for consequences which are the only truly effective answer to too-early pregnancies.

During these hearings many dedicated men and women will tell you of their work with pregnant teenagers. You will be given facts and statistics to support the need for a comprehensive approach to the problems of teenage pregnancies.

I ask only that you think of this legislation as an essential part of our national commitment to family-building and family-renewal; to the creation of a physical, emotional, and spiritual environment in which the birth of a child and the creation of a family are treated with the respect and reverence they deserve.

"The family," as a philosopher once said, "must be the foundation of our national life. It is there...that our character is formed."

This troubled, fragile, yet most indispensable of all our human resources is yours to protect. I ask for your wisdom and your compassion.

Thank you.

Senator KENNEDY. Next will be our panel of teenagers: Joanne Saffer, Valerie Kee, Tajuana Roberts, and Gloria Baylor.

Dr. HARDY. Senator Kennedy, may I suggest that you ask Joanne Saffer's husband, who is here, to join the panel? He was an adolescent father and should be very helpful.

Senator KENNEDY. That is an excellent suggestion. Mr. Saffer can come up, too.

Joanne, I think we will start with you.

STATEMENT OF JOANNE SAFFER, EDUCATIONAL-VOCATIONL COUNSELOR, JOHNS HOPKINS CENTER FOR TEENAGE MOTHERS AND THEIR INFANTS; VALERIE KEE, A PATIENT FROM JOHNS HOPKINS COMPREHENSIVE CARE CENTER; GLORIA BAYLOR, HIGH SCHOOL STUDENT, DISTRICT OF COLUMBIA; TAJUANA ROBERTS, DISTRICT OF COLUMBIA TASK FORCE, ADOLESCENT SEXUALITY AND PARENTING, ACCOMPANIED BY DANIEL SAFFER, A PANEL

Mrs. SAFFER. Senator, I am now 25 years old. I am married and the mother of an 8-year-old son. I have been working in the Johns Hopkins program for about 3 years and I am completing my graduate studies in clinical psychology.

At the age of 16, I was a junior in a private high school. I was the president of our student council. I had been dating Danny for about a year. We knew very little about human reproduction, and much less about contraception. We never discussed contraception, as we never planned to become sexually active. So, we were totally unprepared when we did become sexually active.

Pregnancy was never discussed, mainly because we naively thought that pregnancy would never happen to us. However, a month later, I thought I was pregnant. We denied the pregnancy for a very long time, and combined with the emotional stress, we did not tell our families until I was 5 months pregnant.

Senator KENNEDY. What were you fearful of?

Mrs. SAFFER. Mainly family reaction and the fact that I would have to leave school. So, we denied it for about 5 months. The different options that we had available were discussed with us by our parents.

Senator KENNEDY. So, then after 5 months, you did tell your parents?

Mrs. SAFFER. We told our parents, and they discussed the options that were available and Danny and I decided to marry at that point. I had to leave school and I was not permitted into the public school system as a day student, so I had to complete my education at the adult night school.

I went to a private obstetrician who told me at each visit that I was doing fine and he would see me in a month. So, I was totally unprepared for labor and delivery, and it proved to be a very traumatic experience.

Parenting a new infant and being a wife and mother were also extremely difficult. Our peers were enjoying regular teenage activities. Our neighbors were in their twenties and thirties. Dan and I really did not fit in anywhere, so we were totally out of place.

Senator KENNEDY. Can you describe a little bit to us this sense of loneliness that you felt from the time you left school when you were

really kind of isolated, unable to continue in school, and you did not have job skills? Most of your lines, I suppose, into your community and family had been pretty well severed. What is the sense of feeling one has in those conditions.

Mrs. SAFFER. Our friends were extremely supportive to begin with, but the novelty of a pregnancy and all the surrounding excitement quickly died down. While they were dating, Dan and I really could not afford to participate in any of their activities.

All of our neighbors were older. Because I was in night school, my contact with peers was really limited. Dan was still in his school, so he may be able to tell you a little bit more about how he felt.

It is just that we could not date at that time. Our lives were different. We did not have the funds available for any type of outside activities.

Senator KENNEDY. So you did not seem to feel that you could fit in either place, either with the teenage friends or with the older people?

Mrs. SAFFER. That is correct.

Senator RIEGLE. Is it correct that the school that you had been going to prevented you from going back?

Mrs. SAFFER. Yes, that is true.

Senator RIEGLE. So you were basically denied the chance to stay with students your own age because the rules of the school work against young women in your situation?

Mrs. SAFFER. Right. At that time, I was asked to leave the private school I was in. Dan made an effort to enroll me in his public school, and the counselor there advised against it.

Senator KENNEDY. The counselor advised against it?

Mrs. SAFFER. Yes. She thought that it would be more suitable for me to attend the night school, which was comprised mainly of adults in their thirties and fourties who were coming back to get their high school diplomas.

Without the support that I had from Danny and from parents, I doubt if we really would have made it. I cannot imagine a teenager, without some sort of support, getting to the place that Dan and I are today.

I have been working in the Johns Hopkins program now for 3 years, and it is only through teaching sex education——

Senator KENNEDY. Then you had your child, is that correct?

Mrs. SAFFER. Yes. That is correct. I had Danny and finished up my education that year in night school. I decided that I really wanted to go to college, so I took him along with me and finished there.

He also is very aware of the differences now between myself and Dan and other parents. He has noticed that we are younger. He is also aware of how many months it takes to have a baby, and he knows our wedding date. I think there are definite effects on young children as a result of adolescent pregnancy.

We are now expecting our second child. It has taken me 8 years to overcome the trauma of labor and delivery. I think it is only through working in the Johns Hopkins program that I have been able to overcome it. I find it extremely difficult to understand how teenagers without program supports can make it through pregnancy, birth, and parenthood.

My husband and my son are the most important parts of my life, but I do not recommend adolescent pregnancy for anyone. The sta-

tistics of adolescent pregnancy are a fact. I would like to ask you to help.

This bill, with its provision for teenage centers and the integration of all those services, is something that would give these teenagers a good start.

Senator KENNEDY. You are working at the center at Johns Hopkins?

Mrs. SAFFER. Yes, I am.

Senator KENNEDY. You are counseling other teenage mothers, is that correct?

Mrs. SAFFER. Yes, sir.

Senator KENNEDY. And you are trying to provide some counsel, guidance, or help to those young people, is that correct?

Mrs. SAFFER. I primarily work as an educational-vocational counselor and encourage the girls to continue their education and find jobs or job training programs in which they can take part.

Senator KENNEDY. Could we ask your husband a few questions?

Could you try and give us your reaction to the whole experience here?

Mr. SAFFER. Well, I imagine my original reaction was one of fear—I was scared, along with Joanne. We both had tremendous fears of what the future would bring for us. We knew that our lives would be changed dramatically within the next couple months, the rest of our lives.

I was greatly worried about our making it as a family; would we be able to possibly make a go of it. At the time, I was working on a part-time basis and I knew there was no way I could finance a family of three. So, luckily, we got a lot of support from our parents and we were able to move in with them until I could graduate from school. At that time, I got a job as an apprentice and from there, I completed the apprenticeship program.

Also emotionally, it is very difficult to adjust. As Joanne was saying, you are completely isolated. I had no activities of my own. I went to school and immediately after classes, I went to work. I worked until late at night, and then I would come home and it was time for homework. Consequently, you just have no other time for anything else. It is very difficult.

Senator KENNEDY. You mean there were not many support systems to try and help you during this period of time, either?

Mr. SAFFER. The one thing I did was to go down and try and get some counseling and try to get Joanne in school, because I knew how much it meant to her to finish. As she said, she was president of the student council and I knew how much it affected her.

So, I tried to get her into my school, and the counselor recommended against it. As a matter of fact, I had to get a statement myself so that I could stay in school as I was married.

Senator KENNEDY. You wanted to stay in school, and yet you still felt pressured to leave school?

Mr. SAFFER. Not really pressured; the only pressure that I felt was that I should have been out supporting Joanne. However, I was in my senior year and I only had several months more to go. Luckily, Joanne's parents let she and I stay at their house, so we did not have that problem, and I finished school.

Senator KENNEDY. You are aware that only 10 percent of the fathers stay with the mothers. Do you think this kind of a program that would provide counseling, help, and assistance to the expectant mother would have a positive reaction in terms of the father, as well?

Mr. SAFFER. I believe that is so, because their program now has a male psychologist who talks with the expectant fathers, and the fathers are encouraged to attend all these classes with their girlfriends or wives.

When we had our baby, I was completely eliminated from the whole process. I fathered the baby—that was it. I knew nothing of the processes of pregnancy or labor and delivery or parenting.

Senator KENNEDY. You have a job now?

Mr. SAFFER. Yes, I do.

Senator KENNEDY. And you have finished college, is that correct?

Mr. SAFFER. No. I finished apprenticeship school.

Senator KENNEDY. Joanne has finished college?

Mr. SAFFER. Joanne is in graduate school, correct.

[The prepared statements of Mr. and Mrs. Saffer follow:]

TESTIMONY ON BILL 2910
COMMITTEE ON HUMAN RESOURCES

My name is Joanne Saffer. I am 25 years old, married and the mother of an 8 year old son. I am a part-time graduate student in Clinical Psychology and for the past 3 years I've worked as Educational/Vocational Counselor at The Johns Hopkins Center For Teen-Age Mothers and Their Infants. At age sixteen, I was living with my family and attending a private school where I was a junior and active in my school's activities. I had been dating Danny exclusively for a year. I knew very little about reproduction and less about contraception. We did not discuss contraception as we had been dating for a year and did not plan to become sexually active, so we were unprepared when we did. We resolved that it would not happen again, and relied on our own personal controls. Pregnancy was never discussed as that could never possibly happen to us. But the next month I thought that I was pregnant. I totally denied the pregnancy for a very long time and that combined with Danny's disbelief meant that we waited five months before we even told our parents. Our fear was so great that we were totally unable to make any plans. My parents offered us various options, and even though we had not planned or discussed marriage, we decided that we would get married. I had to leave school because of my pregnancy, and we moved in with my parents. I was totally unprepared for labor and delivery. I went to a private Physician, but he would just examine me and tell me I was fine. It was a traumatic experience in which I was left totally alone. I had a hard time parenting a new infant and in being a wife. When my husband and I were able to move into an apartment of our own I felt isolated. My peers were enjoying regular teenage activities while my neighbors in their twenties and thirties were active in the PTA, Brownies and Girl Scouts. I didn't fit in either place. Without the constant support and encouragement from Danny and our parents I doubt whether we could have taken the steps that have enabled us to come to the point where we are today. I am presently working in the Adolescent Pregnancy Program and have been for the past three years. It has only been through the experience that I have had in the Adolescent Pregnancy Program that I have been able to eliminate many of the fears that I had retained about labor and delivery and early motherhood. I am now pregnant with our second child and Danny and I are really looking forward to it. I find it extremely difficult, even today, to understand how adolescents without supports, can ever make it. Today, having been a mother for eight years, I am also extremely concerned about the effect of teenage pregnancy and parenting on the child. When Danny was four years old I took him to a park where other mothers were playing with their children. He asked me why the other mothers were ladies and I was just a girl. He now is old enough to understand that it takes nine months for a fetus to grow and develop, and he questions the time between our marriage and his birth. I also think of my early efforts of parenting and know that I am much more prepared to be a mother now than I was at seventeen. Today, my husband and my son are the most important parts of my life, but I would never recommend adolescent pregnancy. The statistics of adolescent pregnancy are a fact and I would like to ask you to help those thousands of adolescents and their children. This Bill with its provision for Teen-Age Centers can give them a good start.

TESTIMONY ON BILL 2910
COMMITTEE ON HUMAN RESOURCES

My name is Daniel Saffer, I am 26 years old, married with one child. I am a partner with my father in a plumbing company and I teach adult vocational education for the Baltimore County Board of Education. I would like to add to my wife's statement and discuss adolescent pregnancy from the adolescent male standpoint. As an adolescent, I had very little accurate information on sex and contraception. What I knew, I learned from my male peers at school. The possibility of pregnancy was not a reality. When Joanne first told me of her suspicions, I didn't believe her. It was not until she was three months pregnant that the possibility became real. I hoped that the insurmountable problems the pregnancy presented would disappear. I didn't know what to do, where to turn to, or who to talk to. And no one approached me. Joanne and I were unable to come up with options on our own because of our intense denial, our fears and our immaturity. I thought about marriage, but I was in school and working part-time earning twenty dollars a week. I knew that there would be no way that I could support three people on that amount. I never mentioned marriage to Joanne until we talked to her father. He was supportive and asked me what we planned to do. At that point, some of my fears were calmed and I proposed marriage. After we married, I tried to get Joanne into my school, so she could continue her education, but permission was denied and I had to get permission to stay in school, as I was married. We lived with her family for the first six months before we were able to get our own apartment. My constant fears were that we would totally go under financially and that we would never make it as a family. I wonder how young men make it without support: particularly without a job or financial aid and without someone to discuss the situation and to help make plans. I can well understand how some young adolescent men would just run away from the problem when with support and encouragement they might just stay. Once the financial worries are eased some of the stresses of an early marriage are much easier to handle. I know about the Adolescent Pregnancy Program from Joanne and other staff members there. I understand that they have a male psychologist who has young fathers groups. I also know they encourage the young men to come with the girls to the clinic and to participate in the classes. Had I been able to attend classes, I might have been a greater help to Joanne and I certainly would have been helped myself. I'm going to make sure that my young son and maybe potential daughter know all about human sexuality, contraception and its availability, and I'm particularly going to make sure that the lines of family communication remain open. Today I'm very glad I have Joanne and Danny. I recommend marriage and parenthood, but not adolescent marriage and parenthood. I hope our son waits for parenthood until he is older, but should it happen to him I hope that society will provide some supports to him so that he will have a chance to succeed against all odds. The hurdles to me seemed insurmountable and I had some support. This bill could give other young families that chance to succeed.

Senator KENNEDY. May we go to Tajuana Roberts? Will you tell us a little bit about yourself?

Miss ROBERTS. I am a graduate of Roosevelt High School and I am on the D.C. Task Force on Adolescent Sexuality and Parenting.

When I was 16, I became pregnant, and my mother did not find out about it.

Senator KENNEDY. You are 17 now?

Miss ROBERTS. I am 19 now. My mother did not find out about it until I was about 8 months along. I did not tell her because I was scared.

Senator KENNEDY. You did not tell your mother until you were 8 months pregnant?

Miss ROBERTS. She asked me, and that is how she found out.

Senator KENNEDY. Why did you not tell your mom?

Miss ROBERTS. I was scared that she would not love me anymore.

Senator KENNEDY. That she would not love you anymore.

Miss Roberts. So, I went to a home and I had it.

Senator KENNEDY. Were you in school all of this time?

Miss ROBERTS. Yes; the school did not know. And then I went to a home for unwed mothers. Then I had it and I gave it away, because I was not ready to accept the responsibility of having a child.

Senator KENNEDY. During this period of time, did you get any kind of medical attention at all?

Miss ROBERTS. No.

Senator KENNEDY. You did not get any medical attention or nutrition advice, and then after you had the baby, did you put it up for adoption?

Miss ROBERTS. Yes.

Senator KENNEDY. And why was that? Did you want to do that?

Miss ROBERTS. Yes, I wanted to give it away because I was not ready for that kind of responsibility.

Senator KENNEDY. What happens to some of your friends? Do they have them and keep the babies that you know about?

Miss ROBERTS. Yes, most of them keep their babies.

Senator KENNEDY. Are more of them keeping their babies than before that you know about?

Miss ROBERTS. Yes.

Senator KENNEDY. Do you find that more of your friends that are having babies at a younger age are keeping their babies now than were a few years ago?

Miss ROBERTS. Yes. My mother did not know anything about sex education and she did not teach me anything. That is why I think there should be a class for parents, so they can know about sex education so that they can teach their kids how and when to have sex, and about the different methods of birth control and how they are used. I also think they should teach sex education in preschool through ninth grades; you know, the simple things, like the parts of the body.

Senator KENNEDY. OK. Maybe we will move on.

Senator RIEGLE. Mr. Chairman, I have a question.

Senator KENNEDY. Sure.

Senator RIEGLE. After you became pregnant—and you were pregnant for 8 months—you said that you were afraid that if you told your

mother, maybe she would not love you anymore, so you have to keep it a secret. Is that correct?

Miss ROBERTS. I was not really afraid that she would not love me anymore. But it semed like everybody was always saying how good I was and I would never do anything wrong. I just thought it was wrong.

Senator RIEGLE. So you were really afraid to tell anybody; it was the kind of secret that you just did not think you could share with anybody?

Miss ROBERTS. Right.

Senator RIEGLE. You did that for 8 months, and so all that time, I suspect that you did not really know what was happening. Your own body was changing, but not having had any classes about what was going on or information about it, I assume that you were probably pretty scared during that time yourself, were you not?

Miss ROBERTS. Yes.

Senator RIEGLE. And there was not any place for you to go, I gather; in other words, there was not a clinic or any other place that you were aware of that you could go to tell somebody the secret, to get some advice from somebody who could tell you what was happening to you? There was not anything like that?

Miss ROBERTS. No.

Senator RIEGLE. And then, finally, when you told your mother, it was not long after that that the baby then came and you went to this home to have the baby?

Miss ROBERTS. Yes.

Senator RIEGLE. How long ago was that? When did this happen?

Miss ROBERTS. About 3 years ago.

Senator RIEGLE. Since that time, has your life been different? I suppose that maybe this is the most important thing that has happened in your whole life so far.

Miss ROBERTS. Yes.

Senator RIEGLE. That is all.

Senator KENNEDY. Senator Hayakawa?

Senator HAYAKAWA. Miss Roberts, have you since married?

Miss ROBERTS. No.

Senator HAYAKAWA. Are you still in school or are you working?

Miss ROBERTS. I graduated.

Senator HAYAKAWA. You did graduate. Are you working now?

Miss ROBERTS. Yes.

Senator HAYAKAWA. Would you tell me where you are working?

Miss ROBERTS. I work at HEW and I am training to be a computer operator.

Senator HAYAKAWA. Good. Congratulations. Thank you very much.

[The prepared statement of Miss Roberts follows:]

TESTIMONY

OF

TAJUANA ROBERTS

Youth Representative
District of Columbia Task Force on
Adolescent Sexuality and Parenting

1101 Fifteenth Street, N.W., Suite LL-70
Washington, D.C. 20005

ON

S.2910

ADOLESCENT HEALTH, SERVICES, AND PREGNANCY
PREVENTION AND CARE ACT OF 1978

BEFORE THE

SENATE COMMITTEE ON HUMAN RESOURCES

June 14, 1978

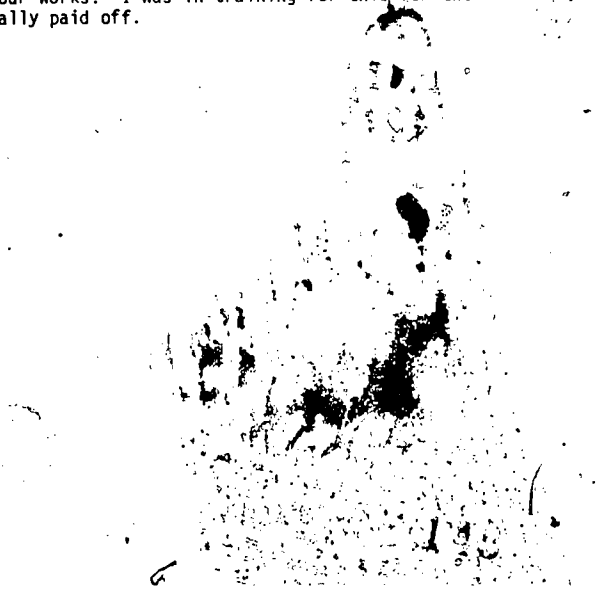
My name is Tajuana Roberts. I am 19 years old and a graduate of Roosevelt Senior High School. I would just like to say that when I was sixteen years old I got pregnant. I didn't know anything about sex education, I didn't know anything about taking care of a baby. I wasn't taught. My mother didn't know. I didn't tell anyone I was pregnant until the eighth month. I was scared. I had the baby and I sat down and I thought. How can I take care of this kid? I don't have money. I don't have a job. I never experienced anything and the father didn't even know about it, so what could I do? I couldn't take care of the baby. I would have to drop out of school, and I know I would regret it. So I gave the baby away.

That's why I think there should be a class in pre-parenting and parenting education for parents. Such a course would contain information on the ethics, morals and values of sexual activities and how to tell your children about sex and when to tell your children about sex and how to tell your children about birth control — what types exist, their dependability, their side-effects, and where they can be obtained. Sex education should be taught in grades pre-school through ninth. Early appropriate topics, such as parts of the body, human sexuality, and getting rid of the myths about sexuality.

Teachers should learn how to talk plainly to students, should learn about sex themselves, should learn about communication and the necessities to answer questions open and honestly. Pre-parenting and parenting education should also be taught in high schools. Separate and mandatory courses like birth control for males and females, the responsibility of parenthood, the birth process, and pre-natal care and education and special and appropriate courses for pregnant students and partners and married students.

There also should be sex education in the streets. Now I'll bet you're wondering how we can get this message across. Well, last year I was on a pep mobile organized by the D.C. Task Force on Adolescent Sexuality and Parenting. It's a mobile research library manned by peer counselors with a doctor and a planned parenthood specialist on it. We went around to different recreation sites and gave out pamphlets on birth control, V.D., and nutrition. We also showed films. We held rap sessions on the van with the kids.

There should also be peer counselors at different community centers where youths can come in and ask questions and get the right answers. There should also be peer counseling in the schools. I am a peer counselor at Roosevelt High School. We have a rap room where students can come in and talk about anything they want to talk about — V.D., birth control, how to buy your works. I was in training for this for twelve weeks, and I think it really paid off.



Senator KENNEDY. Valerie Kee.

Ms. KEE. I am 19 years old, and I am a graduate of Northern Senior High School. I have an 18-month-old son, whom I planned to have, but I did not think it was going to be so hard.

I was introduced to the Johns Hopkins Center when I got pregnant. My boyfriend and I went there; we went to different classes—prenatal, postnatal; nutrition classes; drug abuse classes. And it really prepared me to be a good mother and to recognize myself as a person, and it really made my boyfriend feel as though he had a great responsibility.

I continue to go to Johns Hopkins, and my son still goes, and I find it really rewarding to be there. I really do not want to leave, but I know my time will be up soon. I always wish that all my friends could go there and learn like I learned, because I really was not prepared, either. I was not dumb, and I knew that there was somebody out there that had some backbone that was going to help me. Johns Hopkins just happened to be it.

I hope that every other teenager that gets pregnant and feels like they are lost will go to Johns Hopkins, because that is where you will find the center. It is really rewarding to be there.

Senator KENNEDY. Do all your friends go there?

Ms. KEE. Most of them do.

Senator KENNEDY. What would you say among your friends; do they want to have the baby?

Ms. KEE. Most of them do; most of my friends do have their babies. It seems like most of them are lost and that seems like the only thing—they feel needed, and I figure that that is why they get pregnant, because they want to be needed. They want somebody to love and somebody to need them.

Senator KENNEDY. Do they know that they have information available to them on contraception.

Ms. KEE. They know this, and they knew it long before they got pregnant; it is just something they want to do. It is like a need; it is like they hope—I do not know what it is, but that is the way they feel.

Senator KENNEDY. And without this kind of a resource, this kind of a center, what is the reaction in the community and what is the reaction in the school?

Ms. KEE. Well, they get it, but they do not go as deeply into it as the Johns Hopkins Center does. They just tell you what to expect; they do not take you on tours to the delivery room.

Senator KENNEDY. Well, would they let you stay in school?

Ms. KEE. Yes, I went to Edgar Allan Poe School for Pregnant Girls.

Senator KENNEDY. Could you stay in the school you were in?

Ms. KEE. Yes, I could have, but I decided to leave.

Senator KENNEDY. I see. And you had your baby and it was well and healthy, is that right?

Ms. KEE. Very well and very healthy.

Senator KENNEDY. And what do you do now?

Ms. KEE. I plan to go to Towson University in the fall, and I have been so enthused by this clinic that my major is child psychology and child development.

Senator KENNEDY. What do you think would have happened if there had not been a center like Hopkins?

Ms. KEE. I really do not know. I probably would have been lost. I probably would not be where I am at today; I am really on my feet and I am really willing to go out and take care of myself and help my boyfriend to take care of the three of us. Right now, he is my backbone.

Senator KENNEDY. OK. Miss Gloria Baylor?

Miss BAYLOR. My name is Gloria Baylor, and I am finishing the 11th grade at Cardozo High School here in Washington, D.C. I played center on the girls basketball team last year, and I was on the track team this spring.

I first went to the birth control clinic at Howard University Hospital 1 year ago, after my mother made an appointment for me. I went to the waiting area, signed the roll and the clinic card. When it was my turn, I had a urine test and they took a blood sample.

We talked about what kind of birth control I wanted and they showed me how to take the pill. I have been taking the pill since then and I have been back to the clinic several times, but I have not had any problems.

I know that there are a lot of people my age who need to know that there is some place to go before you get pregnant. Instead of not thinking about it or hoping it will not happen, it would be better if they knew that there was something they could do.

A lot of girls go by what they hear other people say, and they worry about having to pay, or they hear that birth control will give you cancer or messes up your tubes. Sometimes, they are scared the examination is going to hurt a lot, so they need to find out from somebody who knows what will happen.

Senator KENNEDY. I am just wondering on this point, now, that Gloria has mentioned, and I think it is important—and Valerie has mentioned it—that at least in some instances—I do not think we can probably quantify it to the exact percentage—but at least in some instances, and important instances, young adolescent girls have the information about contraception, but still want to have their baby. I think Valerie has mentioned that.

I want to know, from your own experience as a peer counselor, whether you find that to be true, as well.

Miss ROBERTS. Yes, sometimes.

Senator KENNEDY. Gloria, do you have any comments on that? Have you found that to be true, too, or not?

Miss BAYLOR. Would you repeat the question?

Senator KENNEDY. Whether there are some times that young girls know that they can either get contraceptive information or that it is available to them, that they still make a decision to go ahead.

Miss BAYLOR. I think they know that it is available, but they think you have got to take your mother with you to fill out records. Then, if you take your mother and she knows you are going to a birth-control clinic, she is going to be trying to check up on you and see what you are doing all the time.

Sometimes, you just do not want your mother to know what you are doing all the time and getting involved in your personal business. It seems that when you want to go to those clinics, you are afraid you might need your parents to give some income information, and stuff like that.

Mrs. SAFFER. Senator, may I answer that, also?

Senator KENNEDY. Yes.

Mrs. SAFFER. I think there is another reason why contraceptives are not used—I am speaking from my own professional experience—and that is that teenagers link sex and love together, and to plan to have sex somehow takes away from that.

To go, to plan and to get contraceptives somehow seems worse than having sex accidentally. That may not make sense. It may not be logical, but I do believe that is how they feel.

Senator KENNEDY. Valerie, would you agree with that?

Ms. KEE. Yes, that is the way it is. They feel like, "I do not want to do this, because I do not want to make my boyfriend feel bad, making him think I do not want his baby." So, they go ahead and do it, thinking, "I am not going to get pregnant; that does not happen to me."

Then when it happens, it is his fault; they do not want to see him anymore. When you go to the clinic and they ask you, "Did you know about contraceptives," they will tell you, "Yes, but I was afraid to hurt my boyfriend," or something like that.

Senator HAYAKAWA. May I ask Valarie a question?

Senator KENNEDY. Senator Hayakawa?

Senator HAYAKAWA. You said that your boyfriend was most responsible, is that correct?

Ms. KEE. Yes.

Senator HAYAKAWA. He did act with full responsibility. Is he in school or is he graduated?

Ms. KEE. He is working and in school.

Senator HAYAKAWA. He is working and in school?

Ms. KEE. Yes.

Senator HAYAKAWA. Are you married to him now, or are you planning to?

Ms. KEE. No, not yet. I plan to, but not yet.

Senator HAYAKAWA. Does he know you have got these plans? [Laughter.]

Anyway, I am glad you are closing in on him. [Laughter.]

Anyway, this matter of the response to the sense of responsibility of the young man involved; that is what I am very interested in, as you may have heard from my earlier remarks. Very, very often, the young man feels no responsibility whatsoever, and I am very, very glad that your young man did have this sense of responsibility.

Therefore, when you went to Johns Hopkins Clinic, he went with you?

Ms. KEE. Yes, he did.

Senator HAYAKAWA. I see. Well, that is very, very admirable on his part, as well as your own. Thank you very, very much.

Ms. KEE. OK. You are welcome.

Senator KENNEDY. Thank you very much.

Ms. KEE. Thank you.

Senator KENNEDY. I think while we have both heard the testimony on the legislation and about the teenagers in the centers, it probably makes the most sense to have the representatives of the care centers. So, we will have Caroline Gaston, Ruth Drescher, Dr. Janet Hardy, and Dr. Rob Johnson.

Why do we not start with Mrs. Gaston.

STATEMENT OF CAROLINE GASTON, DIRECTOR, NEW FUTURES SCHOOL, ALBUQUERQUE, N. MEX.; RUTH DRESCHER, M.S.W., PROGRAM COORDINATOR, UNITED MENTAL HEALTH, INC., COMMITTEE FOR A MULTISERVICE CENTER FOR PREGNANT SCHOOLAGE GIRLS, PITTSBURGH, PA.; JANET B. HARDY, M.D., PROFESSOR OF PEDIATRICS, JOHNS HOPKINS UNIVERSITY; AND ROBERT L. JOHNSON, M.D., ASSISTANT PROFESSOR AND PEDIATRICS DIRECTOR, ADOLESCENT MEDICINE DIVISION, MARTLAND MEDICAL CENTER, NEWARK, N.J., A PANEL

Mrs. GASTON. Thank you. It is a pleasure to be here today, talking to you about teenage pregnancy. My testimony is in support of the Adolescent Health, Services, and Pregnancy Prevention and Care Act. I have submitted written testimony, which I assume will be placed into the record.

Senator KENNEDY. All of the written testimony will be made a part of the record.

Mrs. GASTON. I would just like to take a few minutes to talk about the thing that I know best—how a teenage pregnancy program works. I will refer to my particular program, which is in Albuquerque, New Mexico.

We have the three basic components that you will see described in the bill, which are health services, education services, and counseling services. There are other important services which you will also find described in the bill.

In the health services component, we have the services of two nurses on our staff. One of the nurses teaches a class called "family living." This is a class that the girls take daily for a full semster with us. In this class, they learn about preparation for labor and delivery, so that they do not have the kind of traumatic experiences that the young ladies described earlier.

They learn about the importance of prenatal health and the importance of prenatal nutrition. If you think about what the diets of typical teenagers are like, I think you will understand why it is very important that these girls have nutrition education and, beyond that, actually have nutrition services.

We are able to provide a free breakfast, a free lunch, and an afternoon snack for these girls, which we think, to a great extent, cut down the number of girls who are eating potato chips, cokes, hot dogs, and that sort of thing.

The nurses make a home visit to each girl, following the delivery of her baby, and they talk with her then about her health status, the health status of her baby, and about her plans for returning to school. Most of our girls miss just 2 weeks of school in the program, and then they are back with us and complete the school semester in which they are enrolled.

During the time of the home visit, the nurse also talks with the girl about her plans for birth control. Family planning is a very important part of our health services and, indeed, a part of the total program of the school. I do not think we can regard family planning as being just a health service, because it does deal with the total individual.

It relates to her goals for herself, her goals for her baby, her understanding of what it means to be a parent, and certainly to her vocational goals, and her vocational capabilities, and skills. I was very glad to hear earlier today the discussions of the importance of economics and the vocational emphasis of this bill.

In our program, we are connected with one of the youth programs, called the youth incentive entitlement pilot project. The girls are able to receive actual jobs and work on our program site, which helps them feel much better about themselves and gives them some goals for the future, and also gives them some money which they so desperately need.

Another part of the comprehensive program services should be education. In our program, the girls may continue with their regular education. It is true that in most schools now, according to Title IX of the Federal regulations, the girls are allowed to remain in their home school. However, it happens very often, as the young girl described earlier, that the regular school counselors counsel them that it would be better if they do not. So, many of these girls do end up dropping out of school if there is not an alternative place where they can go.

In our program, they can continue with their regular education and, in addition, they get some of the special classes that we have been talking about. They get the special class in family living and they get another special class called child development, which is parenting education.

We believe that parenting begins with the girl during the prenatal time. She has to have a good attitude about this baby during the time that she is pregnant if she is going to have a good attitude and be a good parent after the baby is born.

So, we think that this is when parenting starts, and it continues, then, after the birth of her baby. We are fortunate that our parenting education can take place with the child development center right there. The girls bring their babies back to our nursery in our building after the birth of their baby, and then this, in turn, becomes a learning laboratory, so that the girls actually get hands-on, practical experience in caring for a baby and in learning what the responsibilities of caring for a baby are before their own baby comes.

This also gives us an opportunity to observe the girl in her relationship to her baby, and we think that this helps us to be able to note if there are any problems and to help her become a better and responsible parent.

The third component of a comprehensive program, in addition to health services and education services, is counseling services. Counseling services have several goals. They should be aimed toward helping the girl, first of all, to accept the situation that she finds herself in, and to realize that she can go forward, that she can have a future, and that she will be able to be a contributing member of our society.

Counseling has to help her learn how to cope. A good many of the problems of child abuse and neglect may come just from fears, anger, and frustration that parents do not know how to handle. So, coping is a major part of the social service or counseling component of our program.

Vocational counseling and educational counseling are also a major counseling component. All of our girls are involved in a group-

counseling session once a week, and individual counselors are available to them whenever they choose to use that counselor.

I am sorry that Senator Hayakawa has left. We do involve the young fathers in our program. There are counseling opportunities in the evenings when the young couples or the young fathers, alone, may come for counseling. We talk with them about the responsibilities of being a parent, about family planning, and about their vocational goals and possibilities.

I think it is important that we consider carefully the kind of coordination and linkages that are indicated in this bill. I believe very strongly in the coordination component. In a community which does not support this kind of a program, the program would not be possible. The community must support the program.

However, I do not feel that the coordination and linkages aspect of the program is as expensive as is indicated in this bill, and I would recommend that the limit, instead of being 50 percent on services, be raised to 75 percent on services.

I have indicated in my written testimony the different kinds of programs that are included; the different voluntary agencies, public agencies, and private agencies that are included in the support of New Futures School. I think that this can be an example of the kind of functional, service-level linkages in which we are interested. Yet, it is not as expensive as is indicated, and I would like to suggest a change in that area of the legislation.

Ours is a school-based program. You will find that other communities will have hospital-based programs, and we will talk about that later on. We will talk about some places where it will be a social agency-based kind of a program, and I think it is the strength of this legislation that it allows the community to develop a service program according to the needs and the interests and the capabilities of that particular community. I think this is a real strength that should be included in the final legislation.

I want to talk a little bit about—to follow up on some of the things that you heard from the young girls who expressed them so eloquently just now—family planning and primary prevention. Family planning involves much more than making birth control or contraceptives available to teenagers.

There is a big missing link between making them available and getting the teenagers to use them. Right now, I do not think we have the capability or the knowledge of bridging that gap entirely. We must develop some family planning programs that talk with the girls about their total personalities, about their goals in life, and about their relationships to themselves and their respect for others.

The young girls talked very clearly about how many teenagers believe it is wrong if you plan sex ahead; it is less romantic, and it makes you not as good a person. The girls explained that very clearly, and I would just like to emphasize that that happens in many, many cases. This is where many of the problems occur now and will continue to occur, whatever the availability of birth control and contraceptive centers may be.

So, until we are able to bridge that gap and until we are able to improve and broaden the kind of education and counseling services that are available to young women in their regular schools or in their

youth centers, or wherever they may be—we need support services for teenage parents. I want to emphasize that one-third of the girls that we serve were school dropouts before they ever became pregnant. So, we are talking about girls that the schools have not reached in some way.

They actually re-enter the educational process as a result of the pregnancy, realizing that they need to make something of themselves and improve their education; they want the services of our program, so they come back in.

So, until we find a way to reach these young people, I think we have got to have the kinds of support services for teenage parents that we are describing here today.

I would just like to close with reading one thing, and this is a statement that came from our own students. We have a graduation ceremony each year, because we are a school-related program. A lot of the girls graduate from high school, during the time that they are with us.

We have a graduation ceremony because they feel so much closer to our program than they do to the home school from which they are actually receiving the diploma. So, we have a ceremony, a very traditional and a very emotional kind of a ceremony. I would like to close with just a few words from that.

It says:

> We the senior class of 1978 would like to express our gratitude to all of the staff of New Futures school. By providing a school for young mothers, you have given us the opportunity to complete our education. You have given us hope for the future. Through the year, we have all gained an understanding of what it means to be a responsible parent.
>
> The staff at New Futures did not tell us that we might be good parents if we try. Instead, they taught us that we must be good parents, regardless of our own personal trials and temptations to be otherwise.

That, alone, says it all, and I thank you for the opportunity to talk with you today.

Senator KENNEDY. In your testimony, you list the various agencies where you draw your money from; I guess there are 10 or 12 different agencies.

Mrs. GASTON. Yes.

Senator KENNEDY. What percent of the time do you spend on grantsmanship?

Mrs. GASTON. That is a very important point, because this is the kind of thing that you have to——

Senator KENNEDY. You seem to be a person that understands the concept and is strongly committed to it. And it would appear to me that you have to spend an awful lot of your time just weaving your way through these various kinds of programs.

Mrs. GASTON. That is right; not only in preparing the grants and contacting the sources, but then preparing all the variety of reports that each of these grants require. A third to a half of my time probably goes for this.

Senator KENNEDY. How much?

Mrs. GASTON. A third to a half of my time.

[The material follows:]

NEW FUTURES SCHOOL

	'71-'72	'72-'72	'73-'74	'74-'7[illegible]	'75-'76	'76-'77	'77-'78 (Apr.12)	
ENROLLMENT	119	120	151	193	214	244		
Anglo	42 (38%)	46 (39%)	55(36%)	71 (37%)	70(33%)	80(33%)	65 (27%)	
Black	11 (10%)	11 (09%)	14(09%)	12 (06%)	15(07%)	14(06%)	19 (08%)	
Chicano	54 (48%)	56 (48%)	69(46%)	102 (53%)	121(56%)	136(55%)	142 (60%)	
Indian	5 (04%)	7 (06%)	13(09%)	8 (04%)	8(04%)	14(06%)	10 (04%)	
GRADE								
12th	46 (41%)	48 (41%)	55(36%)	67 (35%)	62(29%)	71(29%)	66 (27.5%)	
11th	30 (25%)	33 (27%)	39(27%)	50 (25%)	79(37%)	90(37%)	101 (42%)	
10th	25 (23%)	26 (23%)	35(23%)	49 (25%)	47(22%)	61(25%)	47 (20%)	
9th	7 (06%)	7 (06%)	14(09%)	17 (09%)	18(08%)	17(07%)	14 (06%)	
8th	2 (02%)	2 (02%)	3(02%)	3 (02%)	7(04%)	2(01%)	6 (2.5%)	
7th	1 (01%)	1 (01%)	2(01%)	3 (02%)	0(00%)	3(01%)	3 (01%)	
AGE								
20	0 (00%)	0 (00%)	1(01%)	0 (00%)	0(00%)	3(1.5%)	2 (01%)	(+ 2-21 yrs.
19	3 (03%)	7 (07%)	3(02%)	6 (03%)	6(03%)	4(02%)	5 (02%)	
18	12 (10%)	18 (15%)	25(17%)	34 (18%)	28(13%)	34(14%)	26 (11%)	
17	36 (30%)	38 (32%)	54(36%)	61 (32%)	79(37%)	75(31%)	85 (36%)	
16	36 (30%)	46 (38%)	36(24%)	45 (23%)	60(28%)	75(31%)	75 (31%)	
15	17 (14%)	18 (15%)	25(17%)	30 (16%)	32(15%)	41(17%)	35 (15%)	
14	6 (05%)	6 (05%)	4(03%)	15 (08%)	6(03%)	8(03%)	6 (2.5%)	
13	0 (00%)	0 (00%)	1(01%)	0 (00%)	0(00%)	2(.5%)	1 (0.5%)	
PREVIOUS DROP-OUT						20%		
CONT/COMP. ED.		79%	78%	78%	75%	74%		
MARRIED	54 (47%)	63 (52%)	61(40%)	56 (29%)	77(36%)	65(27%)	52 (22%)	
BIRTHS	85	73	109	107	134	140	111	
ADOPTIONS	11 (13%)	12 (17%)	21(20%)	22 (20%)	18(13%)	33(24%)	12 (11%)	
BIRTH/COMP.		14%	9%	9%	9%	17.8%	15%	
CAESARIANS		5%	6%	5%	7%	8%	5%	
PREMATURES		6.5%	3%	7.5%	4.5%	10%	5%	
MISCARRIAGES		5%	1%	4%	2.5%	2.1%	2%	

Inter-agency Network Serving School-Age Parents

New Futures School - Albuquerque, New Mexico

The purpose of the following paper is to describe the inter-agency relationships of New Futures School, a comprehensive program for school-age parents in Albuquerque, New Mexico. The paper describes this pattern as it exists during the 1977-78 school year. The pattern is, and should be, a fluid one, developing and adapting to changing needs and capabilities within the community.

1. Albuquerque Public Schools

APS involvement with NFS has grown each year since the program began in 1970. Now the prime sponsoring agency, APS provides the facility, academic teachers and support costs, an administrator and two secretaries, and is the fiscal agent for the majority of the federal funds.

NFS staff make presentations regarding teenage pregnancy and human sexuality to 1500-2000 students in regular APS classes each year.

2. New Futures, Inc.

New Futures, Inc. is a private, non-profit agency formed when the YWCA ceased its sponsoring relationship with New Futures School in 1975. It provides a mechanism for community input and community support, and provides funds for several NFS services.

3. New Mexico Family Planning Council

NMFPC entered into a relationship with NFS in 1976. Title X and Title XX funds for NFS are contracted by NMFPC. The NFS Director serves on the Board of NMFPC. NFS staff have served as resources for statewide training workshops sponsored by NMFPC.

4. State Department of Education

a. Vocational Education Unit

Vocational Education has funded NFS activities since 1976, through Consumer and Home Economics funds contracted to New Futures, Inc. Vocational Education funded development of a textbook, Teenage Pregnancy: A New Beginning written specifically for the use of teenage parents. This book stresses pre-natal health and attitudes toward parenting beginning in the pre-natal months.

b. School Food Service Division

Since 1973, funds contracted by this agency have enabled NFS to serve free a breakfast, lunch, and afternoon snack to NFS students. The program began on a small scale with afternoon snacks and has grown to be an integral part of the NFS health program. Meals are specially planned and prepared to meet the needs of expectant teen mothers.

5. Bernalillo County

Bernalillo County has provided funding for New Futures School services since August, 1973.

6. Birthright of Albuquerque, Inc.

Birthright has inter-related with NFS since it was organized in Albuquerque in 1972. Birthright refers many students to NFS. NFS students receive services from Birthright such as help with housing, transportation, and clothing for themselves and their babies.

7. Chaparral Home and Adoption Services

This agency and NFS have worked closely together since 1974. Girls who reside at the Chaparral home attend the NFS program during the day. NFS is the largest referral source to Chaparral. The Chaparral counselor often uses the NFS facility while counseling with students. The Chaparral counselor and NFS counselors keep closely in touch.

8. Civic Organizations

a. The Pilot Club of Albuquerque finances and participates in the NFS graduation each year. Club members assist in planning and hosting the reception following graduation.

b. Opti-Mrs. Club donates to New Futures, Inc. annually.

c. The Rotary Club of Albuquerque donates to New Futures, Inc. annually.

d. The Mile-High Optimist Club donates silver to the dentist who provides free dental care to NFS students.

e. General Electric's Good Neighbor Fund donates money to New Futures, Inc.

f. The University of New Mexico's Combined Fund donates money to New Futures, Inc.

9. Maternity & Infant Care Project - University of New Mexico

New Futures School and M & I have worked closely together since 1970. NFS provides a facility in its building for a weekly M & I pre-natal clinic for NFS students. All pre-natal care is free to students using this clinic (70-75% choose this care). NFS relies on M & I for medical back-up and information. Educational materials and speakers are shared between the two agencies. The M & I social worker assigned to the NFS clinic and NFS counselors meet weekly. M & I also does a monthly High Risk Infant Clinic at NFS. NFS students may be referred to other M & I High Risk Infant Clinics after leaving NFS.

10. New Mexico Department of Human Services (formerly Health and Social Services Department)

a. Social Service Agency

The Social Service Agency of this Department has related to NFS in various ways since 1971. Title XX funds have been contracted by HSSD in support of NFS annually since 1971.

NFS staff refer students in need of financial assistance or adoption information to Social Service Agency staff.

b. Public Health Department

Public Health Department nurses are guest speakers in NFS Family Living classes. The Public Health Department has assisted NFS with immunization of NFS students. NFS nurses may refer current and former NFS students to the Public Health Department's Well Baby Clinics.

11. Planned Parenthood of Bernalillo County

This agency and NFS have worked together since 1970. Many NFS students receive pregnancy confirmation at Planned Parenthood clinics. Many are referred there for birth control following delivery. Two NFS staff serve on the Planned Parenthood Education Committee, and the NFS Director is on the Planned Parenthood Board of Directors. Educational materials and speakers are shared.

12. Sandoval County

Sandoval County provides funds for New Futures, Inc. services to teenage parents.

13. Tierra Encantada Chapter - March of Dimes

The March of Dimes and NFS have inter-related since 1976 and, to a lesser degree, before that. NFS makes extensive use of March of Dimes educational materials. NFS staff frequently speak at March of Dimes-sponsored functions. March of Dimes has given NFS two consecutive grants to support evening activities with putative fathers and parents of NFS students. NFS students participated in the Mothers March this year. Two NFS staff and one New Futures, Inc. Board member serve on the March of Dimes Board.

14. University of New Mexico

NFS inter-relates with several departments of UNM. The Counseling and Guidance Department places graduate student counselors for field experience at NFS. Home Economics senior students may also have short field placements at NFS. NFS staff regularly speak in UNM Human Sexuality classes.

15. Valencia County

Valencia County provides funds for New Futures, Inc. services to teenage parents.

Through a number of these agencies, New Futures School reaches into communities outside of Albuquerque. Another paper describes that outreach service.

There are other agencies with whom NFS has a good working relationship on a smaller scale. These include the Y.M.C.A., Youth Development, Inc., LULAC, Albuquerque Community Council, and others.

NEW FUTURES SCHOOL
110 BROADWAY BOULEVARD - N. E.
ALBUQUERQUE, NEW MEXICO 87102
(505) 243-0280 or 243-1708

June, 1977

REPEAT PREGNANCY STATISTICS - NEW FUTURES SCHOOL

In December, 1976, the office of Child Health Affairs, DHEW issued a report on Teenage Pregnancy. It states that, when contraceptive programs are unavailable, the frequency of repeat pregnancies for teenage parents is as follows:

6 months	1 year	2 years
18%	44%	70%

New Futures School, a comprehensive program for teenage parents in Albuquerque, New Mexico, maintains follow-up contact with former clients for at least two years after the birth of their baby. Particular attention is paid to the pregnant or non-pregnant status of the former client. The repeat pregnancy rate of New Futures School clients is as follows:

	6 months	1 year	2 years
	2%	6%	19%
No. contacted =	378	- 266	- 113

These figures include documented cases of contraceptive failures. They also include planned pregnancies by married couples who are high school graduates and economically self-sufficient.

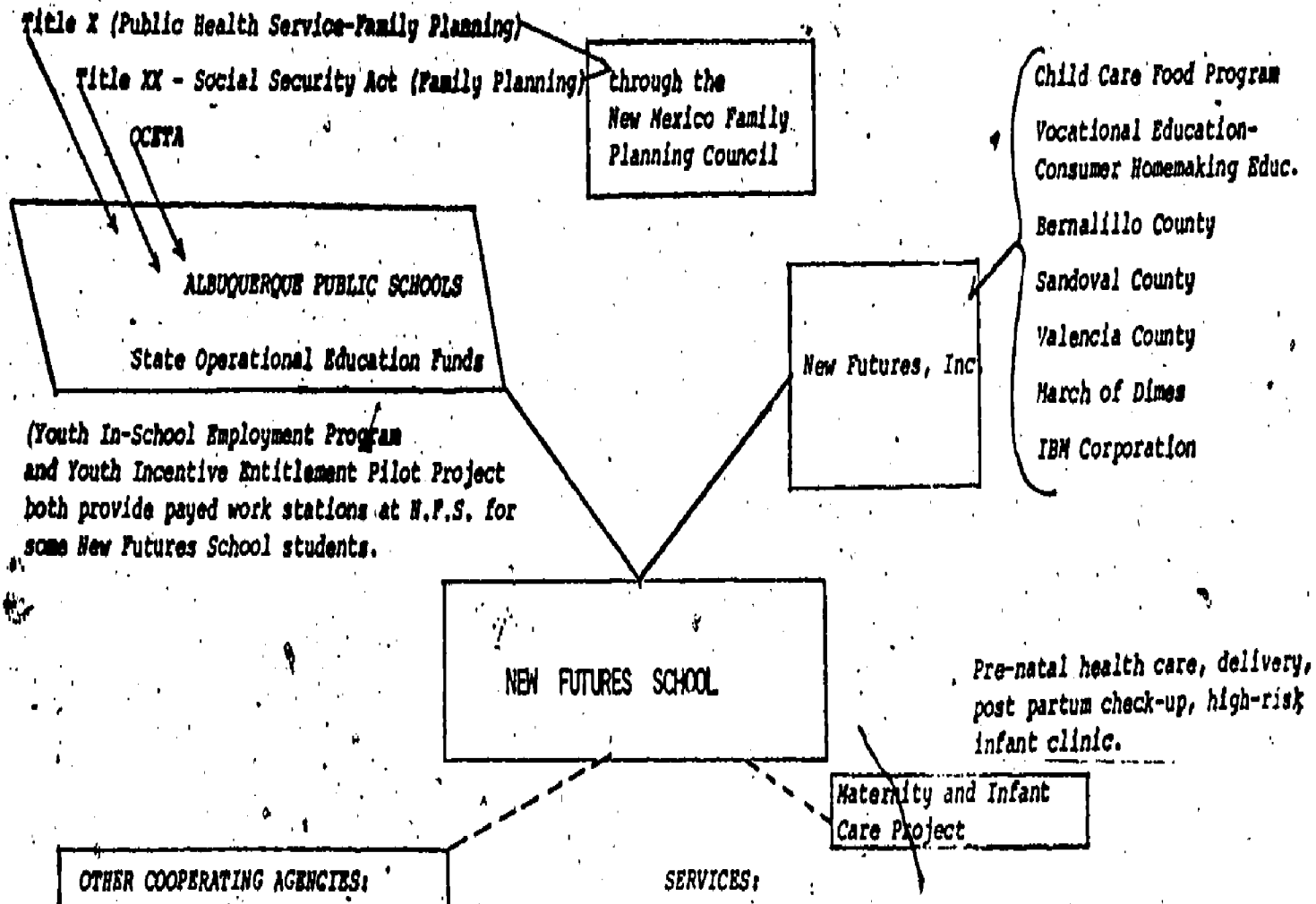
TOM LOCKWOOD, DIRECTOR
PUPIL PERSONNEL SERVICES

ALBUQUERQUE PUBLIC SCHOOLS

(MRS.) CAROLINE GASTON
CURRICULUM ASSISTANT

ORGANIZATIONAL MODEL - NEW FUTURES SCHOOL, ALBUQUERQUE, NEW MEXICO

A Comprehensive Program for Teenage Parents



OTHER COOPERATING AGENCIES:

Birthright
Indian Health Service
Planned Parenthood
Chaparral Home & Adoption Services
State Department of Human Services
Y.W.C.A.
Civic Organizations

SERVICES:

1. Continuing regular education
2. Specialized education in pre-natal health, nutrition, preparation for labor & delivery, child development and parenting.
3. Health counseling and health services, nutrition services.
4. Group and individual counseling - personal, family, vocational; social services and referrals.
5. Infant Day Care
6. Educational and counseling services to family members.
7. Outreach services to community
8. Follow-up services - health counseling, personal and group counseling, social services and referrals.

NEW FUTURES SCHOOL

FUNDING SUMMARY - 1977-78

Total Cost	$290,000
Title X - Public Health Service Act Fiscal Year - June 1 to May 30	$20,476
Title XX - Social Security Act Fiscal Year - Oct 1 to Sept. 30	104,576
Consumer Homemaking Education- Vocational Education Act Fiscal Year - July 1 to June 30	41,000
Child Care Food Program - Department of Agriculture Fiscal Year - Oct 1 to Sept. 30	19,000 (est).

The above are all federal dollars, administered through state agencies. A proposal must be written for each, every year. Different monthly reports are required by each. Fiscal reporting, including cost accounts, are different for each. Funding is unstable from year to year.

Albuquerque Public Schools Operational Funds	102,348
Private Contributions	2,600

NEW FUTURES SCHOOL

STATISTICAL SUMMARY -- 1976-77

Total Number of Clients Served:

In classes: 244
Babies in nursery: 68
Individual and Group Services to Non-enrolled Students: 623
Number of Services to Family Members: 317
Number of Services to Young Fathers: 83

Average daily enrollment - 20-day reporting:

September 22	87	February 2	107
October 20	91	March 3	116
November 22	100	March 31	113
January 5	97	May 5	117
		June 3	105

Number of Clients Served since Program Inception (January, 1970): 1,103

Demographic Data on Regularly Enrolled Clients:

Ethnic Background:	Anglo	80	(33%)
	Black	14	(6%)
	Chicano	136	(55%)
	Indian	14	(6%)
Residence:	Northeast	70	(29%)
	Northwest	53	(22%)
	Southeast	27	(11%)
	Southwest	37	(15%)
	Other	57	(23%)

New Mexico

Alamogordo	2	Sandia Park	1
Belen	2	Sandia Pueblo	1
Bernalillo	3	Socorro	1
Espanola	2	Tijeras	1
Farmington	3	Tucumcari	1
Gallup	2	Zuni Pueblo	1
Hobbs	1		
Isleta Pueblo	3	Other States	
Jemez Pueblo	1	California	2
Laguna-Acoma	1	Colorado	4
Las Cruces	1	Idaho	1
Las Vegas	1	Kentucky	1
Los Alamos	1	Maryland	1
Los Lunas	4	Missouri	3
Mora	1	Oklahoma	1
Mountainair	1	Texas	2
Penasco	1	Wyoming	2
Raton	1		
Ruidoso	1		
Roswell	2		

Statistical Summary

Age:	13 years	2	(.5%)
	14 years	8	(3%)
	15 years	41	(17%)
	16 years	75	(31%)
	17 years	75	(31%)
	18 years	34	(14%)
	19 years	4	(2%)
	20 years	3	(1.5%)
Marital Status:	Married	65	(27%)
	Single	176	(72%)
	Divorced	3	(1%)

Educational Information Regarding Regularly Enrolled Clients:

Grade in School:	7th	3	(1%)
	8th	2	(1%)
	9th	17	(7%)
	10th	61	(25%)
	11th	90	(37%)
	12th	71	(29%)

Classes Offered:

Family Living I
Child Development I and II
Child Care
English - Reading Improvement (grades 7-12)
Physical Education
U. S. History
Your Community
Biology
Typing I and II and III
Shorthand I and II
Bookkeeping and Record keeping
Mathematics (7th grade math through Algebra and Trigonometry)
Spanish I and II (tutoring)
English - Communications (grades 9-12)
Children's Literature
Cooking for Fun
Creative Homemaking
Home Arts
Office Aide

Statistical Summary

Previous school attended:		
	Albuquerque Academy	1
	Albuquerque High	32
	Albuquerque High Nite	1
	Cibola High	7
	Del Norte High	18
	El Dorado High	13
	Freedom High	4
	Highland High	9
	Manzano High	12
	Rio Grande High	26
	Sandia High	10
	Sandia View Academy	1
	School-on-Wheels	1
	Valley High	19
	West Mesa High	19
	Cleveland Jr. High	1
	Garfield Jr. High	2
	Harrison Mid	2
	Hayes Jr. High	3
	Jefferson Mid	2
	Kennedy Mid	2
	McKinley Jr. High	2
	Taft Jr. High	1
	Taylor Mid	1
	Van Buren Mid	1
	Washington Mid	2
	Out-of-town schools	51

(Almost all established residency and were placed on the roll of an APS school.)

Education Summary:

48 students had been school drop-outs prior to pregnancy (20%)

Future Education Plans of N.F.S. students:

Return to school (or graduated)	65%
Plan to return to school after staying out a semester	4%
Work or stay home (not attend school)	16%
Those who had been drop-outs prior to pregnancy continuing with education after attending N.F.S.	38%
Take GED test for high school equivalency diploma	5%
Undecided or unknown	10%

Number moving out-of-town prior to delivery 15

Number dropping out of N.F.S. prior to delivery 36 (15%)

Statistical Summary

Reasons for dropping out prior to delivery:

Going to work	1	
Health problems	1	(transferred to Home/Hospital program)
Didn't want to attend	19	
Husband wanted her to stay home	2	
Parent wanted her to stay home	1	
Transportation problems	7	
No sitter for older child	1	
Unknown	4	

Health Statistics Regarding Regularly Enrolled Clients:

Number od Deliveries 140 (one set of twins)

Complications:

Caesarian sections	11	(one with toxemia)
Toxemia	7	(two with very long labor)
Bloodclots	3	
Breech delivery	1	

Miscarriages 3

Health of baby:

Premature (under 2500 gm)	14	(two with respiratory problems; one with heart murmur; 1 in ICU; one with birth defects)
Infant mortality	0	
Staph infection of cord	0	
Respiratory distress	1	
Possible heart murmur	1	

Number of babies released for adoption 33 (24% of total deliveries)

Number of Home Visits by Health Staff 132
Number of Hospital & Doctor Visits by Health Staff 26

Number of Home Visits by Counselors 43
Number of Hospital & Doctor Visits by Counselors 23

Sources of Referrals:

Word-of-mouth	101	Maternity & Infant Care	7
Birthright	8	APS School personnel	33
Chaparral Home	29	Planned Parenthood	5
Public media	9	Catholic Charities	1
BCMC	6	Farmington Family Plng.Clinic	1
Private doctors	2	Isleta MCH Worker	1
Probation officers	3	Juvenile Detention Home	1
LDS Social Services	1	Youth Development, Inc.	3
Minister	1	Health & Social Services	10
Indian Counselor	1	Los Lunas School Counselor	1

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Statistical Summary

Staff:	
Program Coordinator	1 - full-time
Secretary/Bookkeeper	1 - full-time
Receptionist	1 - full-time
Counselors	4 - 3 full-time; 1 3/4-time; one serves as Administrative Counselor
Para-professional Instructor	2 - full-time
Custodian	1 - full-time
Health Director	1 - 3/5-time
Health Assistant	1 - half-time
Professional Teachers	9 - 6½ full-time equivalencies
Youth In-School Employment Aides	2
Cook	1
Assistant Cook	1 - part-time
Family Planning Secretary	1 - half-time
School-on-Wheels Aide	1

The Health Director and Counselors are involved in team-teaching some classes, and one teacher also serves as individual nutritionist to the students.

Community Information Efforts Community presentations	No.	Attendance
to adults	16	785
to adolescents	44	2,147

In-Building Visits:

Pediatric Nurse Practitioner from Espanola
Mrs. Eunice Shriver, and Kennedy Foundation staff member Herb Kramer
30 Japanese educators on a world tour of educational facilities
DHEW Health Services Administration, Dallas, official
2 youth workers, 3 nurses, 1 counselor, 2 students from Laguna Pueblo
Principal and assistant superintendent from Flagstaff, Arizona
Dr. Charlotte Yeschelman - San Diego State U. School of Education
Ernie Peterson, Associate Bureau Director for Family Planning, Health Services Administration, DHEW, Washington D.C.
Nurses and students from Cuba School District
Kathy Heusel, National Education Representative for Penneys, Inc.
Audrey Moore, staff consultant to DHEW Secretary Califano's Advisory Committee on Rights and Responsibilities of Women
Teacher from a Chicago school for pregnant teens
IBM Corporation Community Assistance Director
State Advisory Committee on Home Economics
Dr. Philip Goldstein, Immediate Past President, National Alliance Concerned with School-Age Parents
Roger Lobodda, State Department of Education, Vocational Division Director of Development and Research

There were also numerous visits from UNM students, APS staff, and Albuquerque human service agency staff.

Statistical Summary

Public Information Media:
- Public service announcements at beginning of school on Radio KQEO, KOB, KRST, and KKKE
- KOB-TV program "Ya Es Tiempo" - Gaston
- Newspaper and television coverage regarding selection of N.F.S. as outstanding program in United States
- KQEO Radio - "Youth Speaks Out" - Sisneros and 3 former students
- Feature article in Albuquerque Journal
- Channel 5 - "APS at Work" - Gaston, Barr, Farrell, Johnson
- KOAT-TV - "Focus" - Barr and 3 students
- Article in Albuquerque Tribune on Maternity Fair
- Public service announcements on radio for Maternity Fair

Conference Leadership:
- State Training Workshop - Vocational Homemaking Teachers - Sisneros - General session speaker
- National Conference, National Alliance Concerned with School-Age Parents - Exhibit and resource leaders - Gaston, Barr, Monserrat, Protomastro, Sisneros
- State P.T.A. Convention - Protomastro - General session panel member
- Southwest Regional Conference, Child Welfare League of America - Workshop panel member - Gaston
- Albuquerque "La Mujer Chicana" conference - J. Sisneros, Griego, V. Sisneros, Madrid, 2 students and 2 parents of N.F.S. students - Workshop panel members
- New Mexico International Womens Year Conference - Gaston - Workshop panel member

Funding Sources:
- Title XX - Social Security Act
- Title X - Public Health Service Act
- Vocational Education
- Albuquerque Public Schools
- Child Care Food Program
- New Mexico Chapter - National Foundation/March of Dimes
- Individual and Group contributions

In November, 1976, New Futures School was selected as the outstanding program for teen-age parents in the United States by the National Alliance Concerned with School-Age Parents

Senator KENNEDY. Dr. Hardy?

Dr. HARDY. Senator Kennedy, I would like to thank the committee for the opportunity to appear here. I did submit written testimony which, in some respects, is rather similar to the very excellent presentation Mr. Califano made, so I will not repeat that part of it.

I think that perhaps I can be most useful in two ways; one, in giving you some idea what a comprehensive program such as the Hopkins program may be able to accomplish; second, in just listing the components of the program.

At Hopkins, we are very fortunate in that we had a child development study going for many years in the same population of people from which we draw the adolescent mothers who enter our program currently. In the child development study we have followed up about 4,800 pregnancies over 8 years, and almost 500 over 12 years, from the point of the birth of the child.

In the child development study there were almost 700 pregnancies in adolescents, and during that period, no intervention was provided. The rate of pregnancy complications was very high. The rate of toxemia, for instance, was almost 30 percent. The rate of prematurity was also very high; it was 22 percent.

The rate of mental retardation was about 6 or 7 percent in the children, as they were followed. The rate of repeat pregnancies in the group followed 12 years is really rather shocking to me. Within 1 year of the birth of their child, 47 percent of the young mothers had a repeat pregnancy. Within 3 years, over 70 percent of them had had a repeat pregnancy, compared with older mothers where perhaps 20 percent of them had a repeat pregnancy within 1 year.

There was a much higher rate of school failure among the children of the young mothers as they got to school age. And when one comes to examine the sources of support, financial support, available to the young mothers, one finds that more than 50 percent of them were receiving welfare support when their children were 7 years old, and more than 50 percent when their children were 12 years old. In fact, only 44 percent were completely self-supporting.

This compares with about 11 or 12 percent of the older mothers when their children were 12 years old. When one looks at the amount of time the young mothers worked during that 12-year period, as compared with older mothers, there is a very striking difference and, of course, it relates to the need for welfare.

The young mothers worked only, on the average, 28 months to 29 months in the 12 years. The older mothers worked an average of 8 years. There was a great deal of marital disruption among the young mothers; 85 percent of them were single at the time their baby was born. And during the 12-year period, 45 percent of the young mothers had more than three changes in partners with whom they lived, whereas only one of the older mothers had three changes or more.

I think that this gives one some idea of the problems that the adolescent mother and her family face. When we compare these outcomes with what is happening in the present program, where support services are offered, we do not have as long a followup. But we have made a significant reduction in the premature rate. We have made a very significant reduction in the rate of complications at pregnancy. The

frequency of repeat pregnancies has been reduced to 5 percent within 1 year, 11 percent in 18 months.

We have been following babies in the followup program for up to just over 2 years now, and there would appear to be a significant reduction in the number of children who are going to be seriously retarded.

When we started the followup program, 90 percent of the youngsters were either not in school or dropped out of school when their baby was born. We now have 87 percent back in school. Part of the schooling problems leading to dropout related to inappropriate school placement for many of these kids. They had undiagnosed, unrecognized learning disabilities, and when placed in appropriate educational situations, schooling is not so painful and they go on to do much better.

I would like to make two further comments. One relates to cost effectiveness. Dr. Cornley of the Johns Hopkins School of Public Health and I calculated one time that if one could cut the premature rate for adolescents on a national basis by 2 percent, one could save $4.5 million a year.

The other point I would like to make has to do with family planning services for adolescents. I think people have made many good points this morning about the fact that adolescents, for various reasons, are not good users of contraceptives.

I would like to add that there really is no ideal contraceptive agent available for adolescents. One would worry about a young woman being on the pill for 20 years, and this might happen to some adolescents. The IUD is an alternative, but there are some serious infections which result from continued use of the IUD and it requires careful supervision.

It seems to me that not only is the availability of contraception needed, but much more than that, contraception needs to be put in a frame of reference of personal responsibility and alternative choices. I would be glad to answer any questions.

Senator KENNEDY. Ms. Drescher?

Ms. DRESCHER. Thank you.

I am here as a representative of the Committee for a Multi-Service Center for Pregnant School-Age Girls in Allegheny County, Pa., and I am employed by United Mental Health, Inc. We have prepared written testimony, which you have in front of you, but it occurred to me as I was listening to testimony that it might be more interesting for you to hear about the situation in Allegheny County, which is somewhat different from what Mrs. Gaston and Dr. Hardy have described, in that we have a long way to go to provide the kind of service for pregnant school-age girls which we feel are necessary.

The committee which I represent is a coalition of some 20 organizations, which was convened by United Mental Health and the Urban League of Pittsburgh, in order to address the needs of pregnant girls in the county. We have some services—we have a school that is currently under the direction of the school district of the city of Pittsburgh, which is called the educational medical school. We have a number of homes for pregnant girls that are primarily church related, and there are probably some 14 agencies, which in one way or another serve the pregnant adolescents of Allegheny County.

The history of this particular committee demonstrates what the needs in Allegheny County are. This group was originally called together in order to support the existing educational medical school which is run by the city of Pittsburgh.

I will not go into a long history of that, except that it was begun in 1966, and it was under the auspices of OEO and the Urban League. In 1971 it was taken over by the city of Pittsburgh public schools, primarily under Title I funds.

The services which this school was providing to pregnant girls, between 1971 and 1975, were becoming less and less, rather than better and better. So this committee, composed of a variety of concerned agencies, was called together to support the school—to appeal to the school board to make the kinds of things happen that we felt were needed.

After about a year of that kind of appeal, it became very clear that this effort was not going to solve the problem. The commitment of the school board was lacking.

The statistics that we had showed that while there was some 400 girls in the city of Pittsburgh who were pregnant, there were another 400 in the county. The committee then began to look at ways of promoting a multiservice center that would serve the entire county. We were extremely pleased to learn of this piece of legislation, and we are very much in support of it. We desperately need it.

We envision a multiservice center which would do the kinds of things which have been described by the other panelists, which would provide educational, social, and medical services, infant care, and services to fathers and families—also vocational and career counseling.

In addition to providing these services, we envison a training component which would help support personnel in the school districts and recognize the needs of pregnant girls.

Prior to the position which I hold now, I consulted with a number of school districts, and it was on more than one occasion that I was greeted by a school administrator with the question, "I have a pregnant girl in my school, how do I get rid of her?"

A charge to a multi-service center for pregnant girls must be to train personnel within the school districts, within the community, and to recognize the needs of these girls.

We also feel that an evaluation component would be extremely important, so that one would know how much has been achieved.

If I could just very quickly refer to some of the points in the legislation which we had addressed in the written testimony.

First of all, there were a number of areas which we would like to applaud.

Senator KENNEDY. We will accept those in your testimony. I want to get to Dr. Johnson, and then we are going to run out of time. I will give you an opportunity to summarize.

Ms. DRESCHER. Let me summarize by saying that we are very much in support of this piece of legislation, not only because it serves pregnant girls, but because it will also serve the needs of their babies.

One particular thing that I would like to say is that the profile of the immature parent is very likely to coincide with the profile of an abusive parent, and we think that is another profound need for legis-

lation of this kind; to provide programs which would minimize child abuse and neglect.

Thank you very much.

Senator KENNEDY. Well, that certainly is of interest, because we have legislation on child abuse. We are interested in that, as well.

Your timing is, I think, critical.

Dr. Johnson.

Dr. JOHNSON. Senator, thank you very much for this opportunity to testify.

Much of what I have said in my written testimony has already been mentioned by others, so I will not dwell on that. But I will make several comments that I feel are important.

I found myself in a unique situation 2 years ago, in that I was hired by the New Jersey Medical School to develop an adolescent program, without any additional funds. Such a situation requires that one scout around in the community to find out what funds are there, and then to stimulate the people to create an adolescent program. So it was a 2-year lesson in linkages.

We have succeeded in that 2-year period, creating three inpatient adolescent services, with a total of 53 beds, and 3 adolescent clinics. Part of our service is a program for the sexually active adolescents, taking care of the pregnancy that results, and preventing pregnancies in the future.

Our essential services for adolescent centers are similar to other services that have been mentioned already, and I will not go into those.

The only additional thing I would like to mention is that one of the things we stress is the attitude of the staff. The staff attitude has been, we feel, the most important factor in making our services more acceptable to our adolescents. The preventive area is where I would like to make some very brief comments.

Pragmatically, our well meaning intentions are doomed to failure as long as we continue to put greater emphasis on the care of the pregnant teenager than the prevention of pregnancy. When we become aware of the escalating rate of sexual activity among teenagers and the decreasing age of sexual maturation, it quickly becomes clear that any legislature efforts which would not emphasize pregnancy prevention would be missappropriation of resources.

Our experience in New Jersey has highlighted three areas of concern:

The greatest obstacle we face in adolescent pregnancy prevention is education. The mind of the 12-or 14-year-old that we attempt to counsel is often so replete with sexual myths and misconceptions that our task is sometimes insurmountable. The inculcation of accurate information at any early age would facilitate acceptance and utilization of preventive methods during adolescence.

Next to the home, school provides the best source for this type of education. Unfortunately, the programs that have been devised thus far, start too late, are taught by persons who are poorly equipped attitudinally, and focus on reproduction and venereal disease—often completely ignoring birth control.

We have advocated that courses in family living be designed to include a broad range of interpersonal relationships. This curriculum should be taught by teachers who are specially trained, and begin in the earliest grades, perhaps the first grade, or even kindergarten.

Second, experience again and again points out the greater success of services which are designed specifically for adolescents. Along these lines, family planning programs which have an adolescent focus attracts more teenagers, and experience better compliance rates. The adult model which briefly explains the contraceptive method, and then requires that the patient return infrequently for followup visits does not work with a teenager who often requires repeated explanation and frequent reassessment of the appropriateness and ultilization of a birth control method.

Finally, pregnancy and its consequences represents the greatest hazard to the physical, social, and psychological health of adolescents in the United States today. It must, therefore, be given a prominent position in the comprehensive health care of every teenager regardless of their degree of sexual activity.

I would like to expand on that point. That is, that every teenager who enters the health care center must be asked about their sexual activity, and the utilization of birth control. It cannot be put aside into a family planning clinic, it must be part of the total health care of the teenager.

[The prepared statements of Mrs. Gaston, Dr. Hardy, Ms. Drescher, and Dr. Johnson follow:]

Testimony of
Mrs. Caroline Gaston
Director, New Futures School
Albuquerque, New Mexico
before the United States Senate
Human Resources Committee
June 14, 1978

It is a pleasure to be here today to talk with you about the problems associated with teenage pregnancy. My testimony is in support of the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978.

You will hear others during these hearings present to you statistics on teenage pregnancy and teenage parenthood. You will hear that 8 out of 10 school-age mothers do not graduate from high school. We must think about the implications of this inadequate education for the young mother and her child as well as for society. You will hear of the health risks to both the school-age mother and her baby, which are great, and you will hear that they are greater with second and third teen pregnancies. You will hear that it is very likely that there will be repeat pregnancies among teen mothers. You will hear about the relationship between adolescent parenthood and welfare dependency.All of these statistics point to the necessity of providing special services to adolescent parents.

I would like in my testimony today to translate these statistics into human terms. What do these statistics mean in terms of the lives of young mothers, their children, and their families? And, to the point of the legislation, how can comprehensive programs for adolescent parents lessen or mitigate the negative consequences of too-early pregnancies?

I speak from a background of seven years as director of New Futures School, a comprehensive program for school-age parents in Albuquerque, New Mexico. I am also an officer of the Board of the New Mexico Family Planning Council, which administers all Title X and Title XX Family Planning dollars in our state, a member of the Technical Advisory Committee to the New Mexico Health Systems Agency, and the editor of a new book for teenage parents entitled Teenage Pregnancy: A New Beginning. In 1976 New Futures School was chosen as the outstanding program for school-age parents in the United States by the National Alliance Concerned with School Age Parents. Through these experiences I believe that I speak from a broad, informed perspective.

Who participates in a comprehensive program for adolescent parents? At New Futures School, 47% of the girls are Spanish surnamed, 35% are Anglo (White), 8% are Black, and 8% are Native American Indians. The average age is 16. Our youngest girls have been 12 years old, in the sixth grade. Some programs see even younger girls. Most (75%) are single. A sizeable number have had previous pregnancies, many terminated by abortions. Nearly a third were school dropouts prior to the pregnancy. Half of them read at or below sixth grade reading level.

The pregnant teen will very likely have waited as long as possible before telling her parents about the pregnancy. She does not want to face the reality of it--just as many adults do not face the reality of cancer or heart conditions, or of their daughter's pregnancy. This means that the young mother is postponing prenatal care, thereby unknowingly increasing the health risks for both herself and her infant.

Try to place yourself in the position of this 15- or 16-year-old girl. At this point in her life she forsees very little future for herself.

Her family, with whom she may or may not have had poor relations before, is angry and hurt because of her. The young man upon whom she relied may well have left her or offered less support than she had hoped for. She does not understand what is happening within her body. She is beginning to dimly understand the financial pressures she will face, although she will probably not come to grips with the reality of this until after the baby is born. Many of her peers--so important to a teenager--have turned away from her. This adolescent, who has previously been allowed to make very few decisions for herself, is suddenly faced with major decisions affecting her entire life, as well as the life of her baby.

This young mother needs help if she is to have a healthy pregnancy and a healthy baby, if she is to make responsible decisions for herself and her child, and if she is to begin a stable, viable family. She needs help which, in a coordinated manner, impacts upon the various problem areas of her life. She needs this help from caring individuals who are attuned to her needs and her maturity level.

How does she receive this help when she participates in New Futures School or a similar comprehensive program?

The three basic components of a comprehensive program for adolescent parents are health services, education services, and social services. There are other services, which are listed in S. 2910, which are very important also.

I would like to follow a 16-year-old girl named Teresa as she received services from New Futures School. Teresa was four months pregnant when she entered the program in late October, after staying home the first two months of school. Teresa was told by her counselor, on her

first contact with New Futures, about the educational classes from which she might choose. All the basic required subjects such as English, history, math, science, and physical education are offered. Family Living class is required. In this class she will learn about the changes, both physical and emotional, which she is experiencing. She will come to understand the reality of the new life within her. She will learn how, and why, she can nurture her child during the prenatal months through good nutrition, good health habits, and regular prenatal medical care. At New Futures School we believe that good parenting begins with prenatal attitudes and habits.

Because Teresa's baby was not due until April, she could wait until the second semester to take Child Development, the other required course at New Futures. In this class expectant mothers have actual experience caring for infants in the program nursery under the expert direction of the nursery care-givers. They also receive instruction from a child development specialist about the physical and emotional needs of the infant and growing child. They learn about child safety, and what to expect of the baby as he or she matures. (Many problems of child abuse are caused by young mothers' unrealistic expectations of their children

One of the New Futures nurses interviewed Teresa during her first visit to obtain her health history. Teresa had not yet seen a doctor--had not even had a pregnancy test--but was sure that she was pregnant because she knew the symptoms from an earlier pregnancy which was terminated by abortion. The nurse made an appointment for Teresa for a pregnancy test with the Maternity and Infant Care Clinic which meets in the New Futures School building each Wednesday afternoon. Teresa's test revealed that she was pregnant. The accompanying VD test revealed no problems.

Throughout her pregnancy Teresa received her medical care from the Maternity and Infant Care program. The doctors and nurses in the Maternity and Infant Care clinic at New Futures School take a special interest in each girl. They are trained to be alert to the special needs of the pregnant adolescent and how to communicate with her. Their medical staff and the NFS nurses keep in close touch regarding the health status of each girl. This relationship exemplifies the kind of functional coordination which is essential in providing services to pregnant adolescents.

During the time she was staying home, Teresa had become very depressed. Her depression affected both her health and her attitude towards her baby. The NFS counselors and teachers worked together to help her begin to feel better about herself and more positive about her future. Weekly group counseling sessions led by a New Futures School counselor facilitated this process. Teresa also saw her counselor regularly on an individual basis.

Soon after she entered the program the NFS nutrition counselor talked with Teresa about her diet. For three days Teresa wrote down everything she ate. As a typical teenager, her list was filled with french fries, soft drinks, hamburgers, tacos, and chili. Together they worked out improvements to her diet which she could understand and afford. Teresa began to eat more of the free lunch served at New Futures which is specially planned to meet the needs of pregnant adolescents. She drank several glasses of milk each day at school, since it was not available at home. She ate fewer "junk foods" outside of school. She believed this was something she could do to help her baby.

The staff noticed that Teresa was beginning to smile more. Her attendance became more regular. She continued to see the New Futures School

nurse often because of numerous aches and pains. She feared that her baby was not healthy because she did not feel well. The nurse's reassurances were very important. When the nurse felt that there might be a real health problem, she immediately took Teresa to a Maternity and Infant Care clinic where she could receive immediate medical attention.

In January, Teresa enrolled in Child Development class. She learned that a baby is happier when its diaper is changed as soon as needed, even if the changing is not a pleasant experience at first for the baby's care-giver. She learned how to hold a baby properly and how to soothe a crying baby. She learned when to start a baby on solid food, and how to keep bottles sanitary. She learned that a baby was a human being dependent upon her for having its needs met, not a doll to be played with. The change was significant.

Teresa's mother took part in the counseling group for parents of NFS students. Through the group she learned better ways of communicating with her children. She also learned many things about prenatal care which she had not known during her own seven pregnancies. She changed some of her cooking habits--those she could afford to change. Most of Teresa's good nutritional intake, however, continued to come from the free breakfast, lunch, and afternoon snack she received at NFS.

Teresa's boyfriend, who had told her during the time they were dating that he would stand by her "if anything should happen," had stopped seeing her soon after he learned of her pregnancy. This happens with many of the girls, but there are some young fathers, both married and unmarried, who participate in evening couples' counseling groups. These groups discuss such things as the male role in parenting, the emotional changes the girl is experiencing during pregnancy, and family planning.

One of the goals of New Futures is to reduce repeat pregnancies. Teresa learned in Family Living class how the male and female bodies function. Many of the myths which she shared with other teenagers about how pregnancy may be prevented were explored, and compared with factual knowledge. Various means of birth control were explained to the girls so that they could make the choice which best suited them. This was only a part of the family planning program, however. The knowledge of how to plan families is of little use without the motivation to use that knowledge and the belief in oneself which allows one to follow through with one's plans. These things Teresa developed as she learned about the responsibilities of parenthood, as she worked through her fears and feelings of inadequacy with her counselor, as she began to have personal and vocational goals for herself.

As the time for the birth of her baby neared, Teresa became more concerned about her financial responsibilities. She was learning about the costs of having a family. She began to realize that she was now financially responsible not only for herself, but for another person, her baby. She was especially worried because she knew her family was unable to provide her with financial help. She talked with her counselor about these new fears. With the counselor's help, Teresa applied for a job through the Youth Incentive Entitlement Pilot Project. She was able to get one of the jobs funded by this project, with NFS becoming her work site. She worked before and after classes as a telephone receptionist. This experience, in addition to giving her much-needed money, helped her develop self-confidence and vocational skills.

Teresa's baby was a healthy, 6½-p[illegible] girl. Soon after Teresa went

home from the hospital, one of the NFS nurses visited her in her home to assess the health of both Teresa and her baby, and to observe Teresa's parenting skills. Teresa returned to NFS two weeks after delivery of her baby, bringing the baby with her to the nursery. She stayed in NFS for the remainder of the spring semester, and determined to return to regular school to complete her high school education while continuing to work through the Youth Incentive Program.

After she left daily enrollment in New Futures, Teresa participated in a NFS follow-up group. Like many young mothers, she needed continuing supportive services, primarily counseling and parenting education, to enable her to cope with her responsibilities.

Teresa graduated from high school on May 26, 1978. She is dating a new boyfriend and is using a birth control method. She has started a full-time job and is now able to afford to place her child in day care. Teresa's problems have not all been solved, but we believe she is well on her way to becoming a contributing member of our community.

I do not want to paint too bright a picture. Not all young mothers who receive the services of comprehensive programs have healthy babies, or complete high school, or stay off welfare, or avoid rapid repeat pregnancies. It is true, however, that the rates of success are much higher for those young mothers and their babies who do participate in comprehensive programs for adolescent parents than for those who do not. The differences are significant enough to make such programs beneficial to society both in terms of cost-effectiveness and improved quality of life.

Few cities have programs as comprehensive as New Futures School. Even for those who do, funding is always tenuous. It would mean a great deal

if the federal government, through the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978, made a statement that support services for teenage parents are important and, indeed, essential.

Not all communities will wish to structure their programs as NFS is structured, nor should they. Some communities will elect to have hospital-based programs, some school-based programs, some social agency-based programs, and some may find other organizational structures. It is a strength of this legislation that such flexibility is permitted.

A program such as NFS cannot exist without community support. I therefore support the coordination component of this legislation. As an example, community and public agencies which provide some kind of funding or services to New Futures School include: Albuquerque Public Schools; New Futures, Inc.; New Mexico Family Planning Council; New Mexico Dept. of Human Services; New Mexico State Dept. of Education, Vocational Education Unit; New Mexico State Dept. of Education, School Food Services Division; Bernalillo County; Sandoval County; Valencia County; Tierra Encantada Chapter-March of Dimes; Bernalillo County Planned Parenthood; University of New Mexico; Maternity and Infant Care Project; Dairy Council of the Rio Grande; Youth In-School Employment Project; Youth Incentive Entitlement Pilot Project; Birthright; Chaparral Home and Adoption Services; Public Health Department; YMCA of Albuquerque; Pilot Club of Albuquerque; Opti-Mrs. Club; Mile-High Optimist Club; G. E. Good Neighbor Fund; Rotary Club of Albuquerque; and the Student Council of New Futures School. To achieve such coordination, there must be a lead agency which provides as many services as possible or practical under one roof and which, through its contacts with other involved agencies, enables the young mother to get services she needs from their resources. If the agencies are not

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working together, the client will feel it and will be adversely affected. The coordination component is not as expensive as is indicated in this legislation, however. The 50% lid on services should, in my opinion, be raised to 75% to ensure the most cost-effective impact upon the client. In addition, we must be sure that coordination and linkages are on a functional service level rather than merely an information and referral "on paper" level.

I wish that there were not a need for such services. I wish that we could prevent all teenage pregnancies. Unfortunately, we do not know how as yet. The provision of birth control services is only a small part of the answer to the problem of teenage pregnancy. The teenager must understand and accept the why, as well as the how, of family planning. This education must include the postponing of sexual activity as a viable alternative. We must learn how to work with those who do not consider themselves to be sexually active (but who occasionally are); with those who want a baby to love; with those who don't know how to say, "No"; with those who think it's wrong to plan to be sexually active, which using birth control implies. We must develop a family planning program which deals with the total individual, which involves the development of a better understanding of the responsibility of being a parent, and which develops on the part of teens a respect for self and others. We need to develop birth control methods which are more appropriate for teens than those that are now available.

Until these things happen, we will need to provide support services for teenage parents, so that they can cope with the untimely pregnancy and develop healthy, stable families.

I would like to quote from the Senior Speech of the 1978 NFS graduating class:

> We, the senior class of 1978, would like to express our gratitude to all of the staff of New Futures School. By providing a school for young mothers, you have given us the opportunity to complete our education. You have given us hope for the future. Through the year, we have all gained an understanding of what it means to be a responsible parent. The staff at New Futures did not tell us that we might be good parents if we try. Instead, they taught us that we must be good parents, regardless of our own personal trials and temptations to be otherwise. That alone says it all.

With this legislation, you can make possible this kind of help for teenage parents. I urge your support for the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978.

Testimony on Senate Bill 2910

Presentation to the Committee on Human Resources

Gentlemen:

May I thank you for permitting me to testify in support of the Administration's Initiative in Adolescent Pregnancy. This is a matter of great concern to me and one with which I have had considerable experience. My testimony will touch briefly on three areas:

(1) the National scope of the problem

(2) the research findings of the Johns Hopkins group

(3) proposed solutions to the problem.

First, let me qualify myself. I am Professor of Pediatrics in the Johns Hopkins School of Medicine and Professor of Health Services Administration in the Johns Hopkins School of Hygiene and Public Health. For many years, I have been Director of the Johns Hopkins Child Development Study and for the past several years deeply involved in the Johns Hopkins Center for School-Aged Mothers and Their Children. As co-director of the Center, I have had responsibility for overall program development with direct responsibility for the development of the follow-up component.

(1) National Scope of Problem - as the Administration has pointed out, the problem is extensive in terms of numbers involved

Data from the National Collaborative Perinatal Study (NINCDS) has shown that 18 and 19 year old mothers have the lowest risk of perinatal mortality of any age group. However, the birth rate for adolescents, i.e., 17 years of age and below, has continued to rise.

In my experience, the problems stemming from adolescent pregnancy result from interaction between biological and social factors related, in large part, to the immaturity of the mother. The important contribution of the biological factors tends to be overlooked. The mother is physically immature, and often in her adolescent growth spurt. She is at high risk of complications of pregnancy, labor and delivery, particularly anemia, toxemia of pregnancy and difficult delivery, all of which compromise the fetus, leading to risks of perinatal death and/or later neurological deficits, risks 2 to 3 times greater than those for the children of older women. The high rates of obstetrical complications and of premature delivery among adolescents result in large costs for special medical care for the mothers, intensive neonatal care and in high risks of sub-optimal development in surviving children. Where special programs are not available 90% of adolescents drop out of school, do not complete their education and thus, limit their employment opportunities. She is more likely to have more children and greater welfare dependency.

and enormously costly to society in terms of money spent for medical care, special education, welfare support and lost productivity. Today, approximately one of every five babies born in the U.S. is born to a teenaged mother. Of the nearly one million teenagers who become pregnant each year, 400,000 are adolescents (i.e., the mother is 17 years or under) and 30,000 are less than 15 years when they give birth. In our experience, a high proportion of these children are unplanned and unwanted. Almost 300,000 elective abortions among teenagers were reported in 1975..

It is toward the problems of adolescent mothers (i.e., 17 years and below) and their children that I wish to direct your attention. They constitute a particularly high risk group and, in my view, should be the target of the Administration's initiative. As this is a considerably smaller group, concentration of new resources and effort should be more productive.

On a national level, the birth rate in all age groups, with the exception of the teenagers, has shown a significant decline over the past decade and, according to recent reports from the National Center for Vital Statistics, the rate for 18 and 19 year olds has also turned down slightly. As sexual activity has increased, this must reflect the availability and use of family planning and elective abortion.

(2) The Johns Hopkins Child Development Study is a longitudinal research study for investigation of factors affecting child development in a large urban population of black and white children and their families. It has been ongoing since 1959. Of the 4800 pregnancies followed from the time of the first prenatal visit until surviving children reached 8 years, 688 were in adolescence, 17 years and below at the time of delivery. Examination of the data shows high risks of complications of pregnancy, low birth weight and perinatal and infant death for these pregnancies. In addition, the surviving children have, on the average, lower IQs and higher rates of school failure than the children of older women. These problems have been documented by others and it is toward new information, pertaining to the outcome for the adolescent mother, 12 years after the birth of her child, that I would call your attention.

The long-range outcome of a group of 77 adolescents 12 years after the birth of their first study child has been compared, along a number of parameters of social well being, with the outcome for a group of primiparous women (20-24 years of age) thought to be in a more optimal age group for successful child bearing.

There is no question that the adolescent mothers in this study were at a serious disadvantage as compared with women in the older

age group with respect to a number of important variables strongly influencing the quality of life and one's ability to successfully nurture one's children.

The young mothers experienced a high degree of family instability, in terms of changes in marital status, as 45% experienced three or more changes during the 12 year period while only one of the older women experienced more than 2 changes and 43% had no change at all.

While maternal educational attainment improved considerably over the 12 years, with the younger mothers, in general, achieving considerably more education after the birth of their study child, than the older mothers, at the end of the 12 year period the adolescents were still far behind, with only 35% having graduated from high school as compared with 77% of the older mothers. Lower educational attainment was paralleled by lower occupational achievement, lower income and greater welfare dependency. At both the seven and twelve year follow-up levels only 44% of the young mothers and their families were fully self-supporting as contrasted with 67% of the older mothers and their families, at the 7 year level and 71% at the 12 year level. The average annual level of social service support in money for these young mothers and their children was $2,147 at the 7 year follow-up

and at the 12 year follow-up it had increased to $2,919, a meager sum from which to provide the resources for a family with an average of 3.25 children. The employment history showed that, on the average, these young women worked slightly less than 20% of the time during the 12 year period, for an average of about 29 months in all.

Increased fertility (47% repeat pregnancies within 1 year and 70% within 3 years), in terms of both live births and fetal deaths undoubtedly complicated the picture for the young mothers, resulting in further taxing of already seriously limited resources, even though public funds through medical assistance provided coverage for medical costs.

It seems likely that having responsibility for rearing a child, frequently without the help of a husband or father, particularly when limited in education and material resources, posed a serious burden which put severe limitations on the educational and employment attainments of these young women. These problems were compounded by the birth of additional children soon after the first, further taxing their resources and ability to cope. An investigation carried out when their study children were 8 years old showed that 70% of these women knew contraception was possible but lacked the basic information needed to control their fertility and to instruct their children about human reproduction.

It is important to emphasize that these differences between the adolescent mothers and those in an older and more favorable age range are based on grouped data and that considerable diversity in outcome actually exists within both the adolescent and control groups. Some adolescent mothers were able to complete their education, develop stable family environments and raise successful children.

(3) Current experience in The Johns Hopkins Center, with a large number of pregnant adolescents and their children strongly suggests that intervention designed to prevent or minimize the mix of biological and environmental problems which relate to adverse outcomes can be highly effective.

(a) Good prenatal care can reduce risks of perinatal death, low birth weight and central nervous system injury;

(b) Supportive psycho-social and educational services during pregnancy, and the hospital stay, can help the young mother delivery a healthy baby and prepare for parenthood;

(c) An ongoing follow-up program can help the young family establish a stable environment for child rearing. Ongoing birth control services, education and supplies can effectively reduce early repeat pregnancy (in our program to 5% within 12 months, 11% within 18 months after the birth of the first child). Individual psycho-social

screening and where needed diagnosis can help young mothers re-enter school or obtain placement in work study programs (87% are back in school after delivery) leading to regular employment. Information about parenting, child development, nutrition, drugs, alcohol, etc. can result in improved adolescent and child health and reduce the risk of child abuse and neglect.

Furthermore, present ongoing research, sponsored by the Office of Child Development, indicates that urban adolescents have, in general, little accurate information about reproduction, contraception, child development and parenting. While difficult to measure, the intervention to supply needed information are not only effective with the adolescent mother, but have a ripple effect extending beyond the adolescent served, providing primary prevention for her siblings and friends, who like herself are vulnerable to adolescent pregnancy and its consequences.

The Johns Hopkins program has several unusual features: (a) fathers are included in the educational program both prenatally and in the Follow-Up where special group discussions on family planning, drugs, child care and other topics are discussed; (b) there are unusually close working relationships with other community agencies including the Baltimore City Departments of Social Services, Education, Health, Recreation, Manpower, Job Corps and private agencies such

as Florence Crittenton. Members of the Center staff serve on advisory committees or boards of these organizations and provide consultant services helping to develop policy in the area of adolescent needs; (c) the young mothers in the group educational sessions are encouraged to help each other; (d) the follow-up period has been extended to 3 years so that support may be available where needed until the child can be entered in Head Start or some other community program for three year olds.

In Summary

The problems stemming from pregnancy in adolescent women are a serious problem. They stem from the physical and psycho-social immaturity which, in many instances, lead to complications of pregnancy and fetal damage on the one hand and to a less than adequate family environment in which to nurture children on the other. Our program strongly suggests that intervention is effective: (1) in preventing or mitigating many of the problems; (2) in helping the adolescent mother to delay future pregnancies, complete her education and to become a contributing member of society.

Finally, why not put all the emphasis on preventing that first adolescent pregnancy? Obviously that is the ideal solution. However, in my experience, it will be many years before we can attain that goal.

Family planning programs, where available, have had considerable success with the 18 and 19 year olds. They have, in general, failed the adolescents. Furthermore, there is no ideal contraceptive for these young people. Effective educational programs stressing family living, values clarification and personal responsibility, child development, parenting and health are desperately needed for all adolescents, boys and girls. Innovative after school programs utilizing the abundant energies of adolescents are needed as alternative activities. To deal with the urgent current problems of unwanted pregnancy, leadership in mobilizing community resources is a must. This is where the Administration's Initiative can be vitally important in focusing attention and leading the way.

Janet B. Hardy, M. D.
Professor of Pediatrics
Co-Director, Center for
Teenage Mothers and
Their Children

Testimony to be presented

to the

U.S. Senate

Health and Scientific Research Subcommittee

on S. 2910

(The Adolescent Health, Services, and

Pregnancy Prevention and Care Act of 1978)

June 14, 1978

Ruth Drescher, M.S.W.
Program Coordinator
United Mental Health, Inc.
(A United Way Agency).
200 Fourth Avenue
Pittsburgh, PA. 15222
(412) 391-3820

Representing:

The Committee for a Multi-Service Center for Pregnant

School-Age Girls in Allegheny County.

Mr. Chairman, and members of the Senate Health and Scientific Research Subcommittee.

My name is Ruth Drescher, and I am here today as a representative of the Committee for a Multi-Service Center for Pregnant School-Age Girls in Allegheny County, Pennsylvania and I am employed by United Mental Health, Inc. The Urban League of Pittsburgh and United Mental Health (both Allegheny County United-Way agencies) created this committee some two years ago in an attempt to address the needs of pregnant girls with the primary focus on preventing the disruption of their schooling and to insure that services be provided for girls who are mentally or physically handicapped. I would like to preface my remarks by thanking you for the opportunity to testify today.

As a coalition of some twenty organizations, we would like at the outset, to offer our support for S. 2910, "The Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978," in that it calls for a national commitment to provide care not only for girls who become pregnant before they are ready to assume the responsibilities of parenthood, but to their babies, who, without the help and support of social legislation will become high risk members of the next generation. We will not reiterate the need for this bill since Senator Kennedy so ably substantiated its necessity at the time he introduced this legislation.

To keep our testimony brief, we will:

1. Highlight the portions of the bill which we think are especially sound;
2. Point out areas where we find weaknesses, and offer recommendations for change;
3. Call to your attention a basic concern.

Highlights

--- We applaud your recognition of the need for integrated programs. Many communities undoubtedly offer a variety of scattered services, which a young pregnant girl may be unaware of, or lack the energy or resources to seek out. The establishment of single-site centers and outreach networks will bring these services within the reach of those who so desparately need them.

--- We strongly support Sec. 102 (c) in which the bill states that there shall be no income eligibility requirements. While we tend to link pregnancy with low-income girls, we find that pregnancy among middle-class school-age girls has been on the increase as well, and we believe that all pregnant girls must have access to the programs which will grow out of this legislation.

--- Sec. 104, which outlines the requirements for grant approval, appears to incorporate all the necessary facets for a program for pregnant girls. May we suggest, however, that the wording of (5) (B) be changed from "mental counseling" to "mental health counseling"? We strongly support the inclusion of (5) (D) which calls for educational services, in light of our knowledge that many pregnant girls become school dropouts.

--- We are pleased to see that the bill provides for the possibility of discretionary waiver in Section 102 (e) which deals with the stipulation that only 50 percent of grants may be used for cost of services, and Section 103 (c) (3) where the Secretary may waive the limitations that the grant may not cover more than 70 percent of the cost of a project in its first and second years.

Recommendations for change

We would like to offer these specific suggestions for changes and additions:

--- In Sec. 2 (Findings and Purposes) (a) (3) may we suggest that among the risks which you point to, you include the higher risk of child abuse and neglect, since the young immature parent (mother or father) is likely to match the profile of a potentially abusive parent?

--- Sec. 102 (a) (6) provides for training, but excludes the possibility of using training institutions and consultants. While we agree that the grantee should be encouraged to develop training programs to serve profesaionals in the community, we feel that the expertise of institutions and consultants should not be absolutely precluded. This provision in the bill might conceivably lead to the "re-invention of the wheel " syndrome.

--- Among the requirements for grant approval (Sec. 104), item (8) asks for "a description of the grantee's capacity to sustain funding as federal funds are phased down and out." We recognize the rationale for this requirement, but we ask that you reconsider this stipulation on the grounds that the amount of energy and effort needed to satisfy that requirement will necessarily detract from the development of the initial program. We would ask that this kind of evidence be required in the second or third year of the grant, rather than in the first.

--- Sec. 102 (e) specifies that only 50 percent of the grant may be used for services. We are pleased that the possibility of the waiver exists, but would respectfully ask that the drafters of the bill specify what the other 50 percent may be used for. If the answer is, as one might assume, that the other 50 percent is to be used for coordination and linkage, we would suggest that there might be many cases in which that might be an appropriate proportion of the grant, but in many other cases, where many new services need to be developed,

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far less than half of the grant would be required for coordination, and perhaps a more realistic requirement would be that at least 25 percent be used for purposes of linkage, and 75 percent for services.

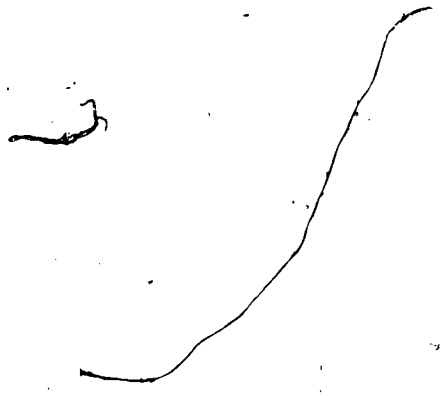
--- Sec. 103 (c) (2) establishes a 70/30 formula for the initial year of the grant. We would call your attention to the difficulties which many agencies might encounter in securing the remaining 30 percent of the budget. In light of the fact that interstate highway construction is reimbursed on a 90/10 formula, and Pennsylvania, for example, has a hard time coming up with the necessary 10 percent, we can imagine how tough it will be to come up with 30 percent to fund a program for pregnant girls. We trust you will agree that the well-being of the next generation is at least as important as interstate highways. We recommend, therefore, that this bill carry a 90/10 formula for the first year of the grant. If there are no spelled-out specifications in the bill as to where the matching funds are to come from, we fear that those who administer the allocation of grants may be more restrictive than you, the legislators, may have intended. Therefore, we would urge you to include in this section the proviso that other federal funds may be used for the match.

--- Our last recommendation, but one of great concern to us, for changes in and additions to the bill is that a section be introduced which will give priority to programs that specifically address the needs of pregnant girls who are mentally or physically handicapped.

Finally, gentlemen, let me return to the basic concern to which we alluded at the beginning of this testimony, which is that of program and service needs for the girl who is already pregnant. These needs are so massive and complex that we are convinced that the entire $60 million which has been identified in this bill should be available for this population so obviously in the greatest need.

On behalf of the Committee for a Multi-Service Center for Pregnant School-Age Girls in Allegheny County, I would like to thank you again for the opportunity of offering our testimony today in regard to this critically important piece of legislation. I will be happy to answer any questions you may have.

KD/dh



Committee for a Multi-Service Center

for Pregnant School-Age Girls

in Allegheny County

FACT SHEET

Agencies represented on Committee:

United Mental Health, Inc.
Urban League of Pittsburgh, Inc.
Pennsylvania Association for Retarded Citizens - Allegheny County Chapter
Allegheny Children and Youth Services Council
Allegheny County Health Department
Women in the Urban Crisis
Maternal and Infant Care Project
Graduate School of Public Health, University of Pittsburgh
Young Women's Christian Association
Allegheny Conference on Community Development
Catholic Social Services
PTA (State Health Committee)
Planned Parenthood Center
Senator Richard Schweiker's Office
Congressman Douglas Wahlgren's Office
Pennsylvania House Speaker K. LeRoy Irvis' Office
Pittsburgh Free Clinic
Allegheny Intermediate Unit
Reproductive Counseling Institute
National Foundation - March of Dimes

Live Births to School-Age Girls Age 17 and Younger in Allegheny County, 1976

Total County - 810

Within Pittsburgh City Limits - 420
Remainder of County (46 school districts) - 390
Mothers under 15 years of age - 39

Approximately 290 girls are enrolled in Pittsburgh's existing facility for pregnant school-age girls

Social implications (According to testimony given by Eunice Kennedy Shriver):

-- Approximately 14 percent of pregnant teenagers attempt suicide
-- Approximately 60 percent of pregnant teenagers receive public assistance
-- Approximately 75 percent of pregnant teenagers drop out of school if no special program is provided.

According to the Delaware Adolescent Program, ". . . the cost to the public for supporting the average teenage girl who becomes pregnant before age 20 and drops out of school is $100,000 during her lifetime."

June 1978

dh

Testimony before the Senate Committee on Human Resources - 6/14/78

Mr. Chairman, for the purposes of this presentation, I have assumed that the listener possesses a level of expertise which makes him cognizant of the scope of the physical, psychological and social consequences of teenage pregnancy and supportive of efforts to modify them. I shall address myself to a delineation of those modifiers and their implementation.

In its simplest form, the problem of the pregnant teenager is biphasic:

a) Care of the pregnant adolescent female and her sexual partner, and methods to make that care more accessible and responsive to their needs. This position obviously necessitates an understanding of adolescent psychosocial development and an empathic attitude.
b) Prevention of future unwanted pregnancies.

At the New Jersey Medical School, we provide obstetrical services to adolescents in separate facilities which are staffed with personnel who have developed an approach to the teenager which is based on an awareness of her psychosocial and developmental stage; thus, encouraging utilization of services and compliance with therapeutic regimens. A major effort is made to counteract the deleterious social consequences by engaging both the prospective teenage mother and father in counseling programs which focus on parenting skills and the dichotomy between the romance of pregnancy and the realities of child rearing.

We recognize, however, that no matter how diligent our efforts, we are often prevented from a totally satisfactory outcome by our inability to impact upon the continued education of the pregnant adolescent. Too

often school systems actively or passively encourage the pregnant adolescent to leave school by failing to provide a curriculum which will comply with the physical and psychosocial demands of pregnancy. Additionally, after childbirth, day care services need to be provided to allow school attendance. The teenage father who often drops out of school to support his child must also be educated. Now that we have developed methods of physical and social care for the teenage mother and father, we must focus on a method which will allow them to complete their education and provide a means of future support for themselves and their child.

Pragmatically, our well meaning intentions are doomed to failure as long as we continue to put greater emphasis on the care of the pregnant teenager than the prevention of the pregnancy. When we become aware of the escalating rate of sexual activity among teenagers and the decreasing age of sexual maturation, it quickly becomes clear that any legislature efforts which would not emphasize pregnancy prevention would be misappropriation of resources.

Our experience in New Jersey has highlighted three areas of concern:

a) The greatest obstacle we face in adolescent pregnancy prevention is education. The mind of the 12 or 14 year old that we attempt to counsel is often so replete with sexual myths and misconceptions that our task is sometimes insurmountable. The inculcation of accurate information at an early age would facilitate acceptance and utilization of preventive methods during adolescence.

Next to the home, school provides the best source for this type of education. Unfortunately, the programs that have been devised

thus far, start too late, are taught by persons who are poorly equipped attitudinally, and focus on reproduction and venereal disease - often completely ignoring birth control.

We have advocated that courses in Family Living be designed to include a broad range of interpersonal relationships. This curriculum should be taught by teachers who are specially trained and begin in the earliest grades.

b) Experience again and again points out the greater success of services which are designed specifically for adolescents. Along these lines, family planning programs which have an adolescent focus attract more teenagers and experience better compliance rates. The adult model which briefly explains the contraceptive method and then requires that the patient return infrequently for follow-up visits does not work with a teenager who often requires repeated explanation and frequent reassessment of the appropriateness and utilization of a birth control method.

c) Finally, pregnancy and its consequences represents the greatest hazard to the physical, social and psychological health of adolescents in the United States today. It must, therefore, be given a prominent position in the comprehensive health care of every teenager regardless of their degree of sexual activity.

Robert L. Johnson, M.D.
Assist. Professor of Pediatrics
Director, Adolescent Medicine
New Jersey Medical School

Senator KENNEDY. Thank you very much for your appearance, and we will recess until 1 o'clock, and then Senator Riegle will chair the hearing.

[Short recess.]

Senator RIEGLE [presiding]. The committee will come to order, please, and let me invite those that are standing to find seats, if they can. Let us begin with panel No. IV. I would like to invite them to come forward.

Faye Wattleton, president, Planned Parenthood Federation of America and Ms. Leslie Tarr Laurie, member, board of directors, National Family Planning Forum; and executive director, The Family Planning Council of Western Massachusetts, Inc.

I am delighted to have both of you here, and we appreciate your patience today.

As you know, the various members of the committee are having to travel back and forth between various other committee meetings and assignments, and so I appreciate your patience in waiting for us.

Have you decided who is to go first?

STATEMENT OF FAYE WATTLETON, PRESIDENT, PLANNED PARENTHOOD FEDERATION OF AMERICA; AND MS. LESLIE TARR LAURIE, MEMBER, BOARD OF DIRECTORS, NATIONAL FAMILY PLANNING FORUM AND EXECUTIVE DIRECTOR, THE FAMILY PLANNING COUNCIL OF WESTERN MASSACHUSETTS, INC., A PANEL

Ms. WATTLETON. Mr. Chairman and members of the committee, I am Faye Wattleton, president of the Planned Parenthood Federation of America. Planned Parenthood, established more than 60 years ago, is the Nation's oldest and largest voluntary family planning advocacy and service organization, which in 1977 provided educational and medical services to more than 1 million people at some 766 clinic facilities.

I appreciate your invitation to be with you today to express Planned Parenthood's views on S. 2910, the administration's proposed "Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978."

At the outset, Mr. Chairman, I want to express Planned Parenthood's strong support for a nationwide, targeted initiative designed to confront and deal, on a comprehensive basis, with the serious and growing problem of adolescent pregnancy and childbearing in the United States.

I will not go into all of the statistics, because you have certainly heard them in terms of the parameters of the problem. However, the failure thus far of our society to deal with these problems in a meaningful way—the failure, indeed, even to recognize and to acknowledge the existence of these problems until very recently—is part of our failure as a society to deal, on a realistic public policy basis, with the most elemental realities of human sexuality.

For too long we have preferred to ignore what is happening, or to long for a return to the old days when—some say—such things did

not happen. And, for too long we have continued to pretend that such things do not happen to "good" girls from "good" families.

Even now, I fear, such a delusion exists among much of our citizenry and its elected leadership, but the data clearly should disabuse us of such notions. Adolescent sexual activity, unwanted adolescent pregnancy, adolescent abortion, and adolescent childbearing are phenomena which occur without discrimination on the basis of race, religion, economic status, or geographical location. These are nationwide problems, which have the potential to affect all of our children, and our public solutions must reflect that fact.

While it is legitimate that programs of Government aid be geared primarily to the needs of the poor, because it is they who can cope least well with the impact of these phenomena, we must recognize that some components of a comprehensive program in the area of teenage pregnancy, such as sex education and other preventive services, must be available to all our young people.

But we must never, in any way, imply, through rhetoric or policy decisions, that it is only the poor who are affected by early sexual activity and its consequences. To do so is only to deny the truth.

Planned Parenthood believe that a truly comprehensive program of reproductive health and social services for teenagers must encompass the following three elements:

Preventive services, including support for the role of parents in the education of their own children, but emphasizing the provision to all young people of basic education, honestly presented, on sexuality, pregnancy, and reproduction, fertility control and the responsibilities of parenthood and family life, as well as the provisions of preventive fertility control services to sexually active teenagers who wish to avoid pregnancy;

Early pregnancy detection services and education related thereto, accompanied by sensitive and balanced counseling designed to insure the exercise of free and informed choice by pregnant teenagers with respect to the outcome of their pregnancies; and

The provision of comprehensive health, education, and social services to those pregnant teenagers who wish to carry their pregnancies to term, and to young parents and their babies.

In addition, the development of safer, more effective and more acceptable means of contraception, which would be of benefit to all our citizens, must be viewed as having particular importance in meeting the needs of the adolescent population.

In this regard, we commend the administration for recognizing the necessity for expanding these research efforts in this year's budget request, and urge that it be seen as only the first step toward a genuine and long-term national commitment to the creation of a new generation of safer and more acceptable means of birth control.

Planned Parenthood reaffirms its belief that prevention is the most effective, the most humane, and, in fact, the most desirable way to deal with the epidemic levels of unwanted teenage pregnancy in the United States, as indeed it is with all unwanted pregnancies.

We pledge our cooperation to all persons and institutions which share our concern with the current incidence of such pregnancies, with the number and consequences of unwanted births, or alternatively, with the number of abortions.

In this context, we commend the administration for attempting to heighten the awareness of this Nation in regard to these problems. At the same time, we regret that in its budget request earlier this year, it paid only scant attention to the preventive components of a comprehensive approach to respond to them adequately. In sharp and welcome contrast has been the leadership of Congress, especially the House Committee on Interstate and Foreign Commerce and the Senate Committee on Human Resources.

We must call attention to the fact that this administration has failed, as past administrations have also failed, to develop and propose a truly comprehensive program to meet the urgent need of young people for information and education related to sexuality, reproduction, parenthood, and family life.

Under the impetus of Congress, education in these subjects has been routinely conducted in Title X programs for some time. But we commend this committee for acting this year to expand these efforts through the authorization of community-based education programs as part of the Title X renewal legislation. We hope that the Senate will work diligently in conference to retain this important provision.

We believe such programs—which will have the local support and input necessary to gain acceptance in their communities—will be an effective beginning to the implementation of truly comprehensive and meaningful sex education programs for all our young people.

We hope that, in time, the administration and Congress will finally recognize that continued ignorance is the cause of, not the answer to, so-called irresponsible behavior on the part of teenagers, and will put its full weight behind such a program.

Despite the best preventive programs, unwanted pregnancies will continue, as they will among adults, to occur among our young people. In most cases, they occur either because adolescents have not had access to contraceptive education and services, or because there is no method of contraception well suited to the needs of young people, and they consequently either fail to use any method at all, make mistakes in the method they use.

Whether a pregnancy is planned or accidental, however, and whatever its intended outcome, early detection and considered decision-making are essential for reducing health and social risks. Therefore, we believe organized and adequately financed efforts are necessary, first, to inform young people about the early symptoms of pregnancy; second, to make reliable pregnancy testing services readily accessible; and, third, to offer adequate pregnancy counseling. Parenthetically, I would like to recall earlier testimony where it indicated that one of the young ladies had gone to 8 months before her pregnancy was detected.

In spite of its overly ambitious and misleading title, S. 2910 clearly is directed toward the needs of young persons who are parents, or are about to become parents. Planned Parenthood endorses the spirit and ultimate goals of such legislation.

We fully recognize that there is an urgent need, one which has been ignored for far too long, for supportive services of all kinds to help teenagers who become parents, through a difficult time which may shape their life chances, and that of their children, in many fundamen-

tal and generally adverse ways. For school-age mothers, adequate prenatal, obstetrical care, is essential, as is adequate medical care for their infants. For both teenage parents, but again, particularly for the young mother, education and services to help prevent or postpone subsequent pregnancies, as well as assistance in continuing and completing schooling, is an urgent need. So is infant day care. In most cases, supportive services are needed not only as an emergency measure, but for months, and often several years, particularly so in the case of very young teenage parents.

Given the magnitude and complexity of the need, we are deeply disappointed by the proposed legislation, which we believe was based on several faulty premises. Our comments are intended to be constructive, however—aimed toward the speedy adoption of legislation truly capable of making a sound beginning toward meeting the basic needs of pregnant adolescents and young parents.

The first premise is that most of the needed services are available in adequate quantity, quality, and comprehensiveness, at the local community level, a premise clearly not substantiated by available research and experience.

By reserving half of the funds authorized by the proposed legislation for coordination and linkages, the main task apparently is defined as making better use of resources which are either inadequate or nonexistent, rather than developing new and more adequate services. Even so, the manner in which these diverse services are to be linked or coordinated is not adequately set forth in the legislation.

A second premise of the legislation is that the scope of services to be authorized would be intentionally broad and vague. While recognizing that communities differ in their needs, or in the extent to which they have already been able to develop special programs for pregnant teenagers and parents, we must also recognize that individuals within this specific target population have basically the same needs wherever they live. We must clearly define those needs before we set out to meet them. And, in our view, there should be a recognized goal for each of the services provided.

We fear that the lack of specificity in S. 2910 may result in programs which are virtually impossible to evaluate, and activities which cannot be made accountable. Indeed, our experience of more than a decade with federally supported organized family planning program has taught us that a meaningful initiative aimed toward a specific population or problem should be carefully targeted, have specific goals, and sufficient direction to the administrative department which will be implementing those goals built into the legislation.

S. 2910 is clearly inadequate in this regard, as its overly broad title demonstrates. Planned parenthood strongly supports a program of comprehensive supportive services for pregnant teenagers, teen parents, and their babies.

We cannot, however, endorse legislation which sets virtually no specific program requirements, which has no built-in evaluation mechanism, and which fails even to assign priorities among the sundry services which may be—but are not even mandated to be—offered.

Lastly, given the magnitude and complexity of the problem—and the inherently high price tag of the services which will truly help

these young people, such as day care—the legislation authorizes such a limited amount of funds that it is doubtful if more than a minute fraction—perhaps only 5 percent—of the approximately 600,000 pregnant girls who give birth each year could receive the health and social services they desperately need.

If unavoidable budget constraints restrict the funds available, it is even more imperative that we define clearly and narrowly the goals of the program, the size and nature of the caseload to be assisted, the core services to be provided, and the specific ways in which other programs, such as maternity and infant care programs, are to be utilized. And we propose that all of these approaches be utilized.

At the same time, we should be willing to make a long-term commitment to the provision of these services; and to the extent that this commitment is not made in S. 2910, it is both dishonest and potentially self-defeating to promise far more than what can be delivered.

I would say that the issue of teenage pregnancy is one of the most difficult and far reaching that face us. There is much that we do not understand, or know, yet we clearly must make a long-term commitment.

In conclusion, we support and urge the adoption by Congress of a comprehensive health and social services program directed toward the diverse fertility-related needs of adolescents. This would include, first, the enactment this year of the renewal of the Title X legislation at the expanded levels recommended by its relevant committees, which would permit a substantial increase in the availability of preventive family planning services for teenagers, and an expansion of complementary educational programs.

Second, careful consideration and adoption by Congress of a meaningful, well-defined program, with specific goals and administrative mechanisms, to meet the needs of those teenagers who decide to become parents following a planned or unplanned pregnancy—a program in which, among the core services provided, special attention would be given to contraceptive services to prevent subsequent unwanted pregnancies.

And third, expansion of early pregnancy detection education and services programs, and the initiation by Congress and the administration of a deliberate assessment of the kinds of balanced counseling services which would enable adolescents to act knowledgeable and responsibly, in their best interests and those of society.

You may be assured of our continued interest and cooperation in this endeavor.

Thank you.

Senator RIEGLE. Thank you very much.

We have some questions that we want to submit for the record because we are going to be limited in time today, and I want to be sure that the remaining witnesses all have the chance to make their statement.

So, Ms. Laurie, let me suggest to you, and if I may, let me at the same time say to the remaining three witnesses who will be appearing on the next panel, that I would appreciate it if you could try to summarize your comments, maybe within a 5-minute period, give or take a bit. That way there will be enough time for everyone to appear.

Ms. LAURIE. Fine. And I appreciate how long people have been patient in dealing with this issue.

Senator RIEGEL. I do as well. And I again thank everyone for that, because it has been difficult today with all of the things going on with respect to our labor law reform bill on the floor, which happens to be an item that comes out of this committee. Virtually all of the members of the committee have an obligation to be involved in that on the Senate floor today. So that is why you see us coming and going. We arranged to do both things at once.

Let us hear from you now.

Ms. LAURIE. I am Leslie Tarr Laurie, and I am pleased to have an opportunity to be here today. I am representing the National Family Planning Forum, which is an organization, a nonprofit corporation, whose membership includes over 400 agencies, organizations, and individual consumers, concerned about the delivery of family planning services in this country.

I also am executive director of the Family Planning Council of Western Massachusetts, and so I can also give the perspective of a direct provider of care.

I think Faye Wattleton has summarized some of the major concerns that those of us who are involved in family planning have about this proposed bill. There are a number of brief points that I would like to make.

Most significant in looking at this legislation is the issue of coordination service. I was saddened to see a significant proportion of the dollars that were going to be allocated under this bill were going to be spent on coordinating existing services. I think that there is a myth that must have stimulated such an idea, and that is that such services actually exist. In rural areas, the idea that even comprehensive family planning services exist is not even accurate. So the idea that such an array of services as proposed in this bill exist at one location seems also not accurate.

It would seem to make much more sense for a more substantial portion of the dollars to be spent on the initiating of existing services. And I would hope then that at least half, or more than half, of the money would be spent in that way.

Also what I would like to do is just to read one brief section which speaks about the issue of nonjudgmental counseling and education. As a result of the limited time alloted, I will just summarize.

Part of the concern that the National Family Planning Forum has and family planning programs across the country is that when services are provided which are of a sensitive nature in terms of values that the people bring to those services, it is essential that all options be made available to an individual and that we, who are the providers of service, do not eliminate any options for people who seek care.

Especially when we are dealing with the very sensitive area of pregnancies and potential pregnancies, it is particularly important for adolescents that all options be made available. I think any adolescent who is confronted with an unwanted pregnancy, should have all options made available to deal with this serious problem, including problem pregnancy counseling and abortion referrals.

I think any adolescent, or anyone in society, who is confronted with a pregnancy, should have the full array of services made available to her. And I do not feel that under the framework of this bill that the issue of nonjudgemental counseling is explicitly spoken to as I think it need be.

Then, lastly, I think it is important for the committee to recognize that Title X programs do provide very extensive community based education. There has been a history of a number of years and experience in local communities providing a full array of services relating to issues of human sexuality and fertility, including anatomy and physiology.

It would be unfortunate if this bill is looking to duplicate services that are already provided. Rather what we need to do with this legislation is to think about initiating new and important services to begin to grapple with this important problem of teen pregnancy.

Senator RIEGLE. I thank you very much for your summary and comments, and we will make your full statement part of the record.

Let me thank both of you for your appearance and patience. I will bring your points to the other members of the committee and the staffs, and we will weigh them carefully.

Thank you both very much.

[The prepared statement of Ms. Laurie follows:]

TESTIMONY OF

LESLIE TARR LAURIE

In Behalf Of:

NATIONAL FAMILY PLANNING FORUM, INC.
FAMILY PLANNING COUNCIL OF WESTERN MASSACHUSETTS, INC.

Before the:

Committee on Human Resources
U.S. Senate
On
S. 2910

June 14, 1978

Mr. Chairman and Members of the Committee:

My name is Leslie Tarr Laurie and I am pleased to have an opportunity to testify regarding S-2910, the "Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978." I am here today representing the Board of Directors of the National Family Planning Forum, Inc., of which I am a member. The Forum is a private non-profit corporation of national scope with a membership of more than 400 agencies, organization, and consumers dedicated to improving the delivery and availability of family planning services in the United States. In addition, I serve as the Executive Director of the Family Planning Council of Western Massachusetts, a non-profit organization which provides comprehensive family planning health care in that region.

Let me begin by emphasizing that the National Family Planning Forum has long been concerned with the problem of adolescent pregnancy on a national level. We appreciate the fact that through this legislation and these hearings this long-standing and distressing issue is at least being seriously addressed on a federal level. The Forum strongly supports the need for the expansion of medical and support services to pregnant teenagers throughout the nation as well as the need for increased preventive measures for teenagers such as family planning and sex education.

As we are especially concerned with family planning, we believe that a national focus of any legislation attempting to address the problem should be directed at the prevention of adolescent pregnancies, and prevention of subsequent unwanted pregnancies by teenagers. Already, an estimated 600,000 premarital teen pregnancies are avoided annually through the use of contraceptives. However, it has also been estimated that an additional 313,000 unwanted teenage pregnancies occur each year as a result of the inconsistent use and unavailability of contraceptives. We have no doubt that this staggering number could be substantially reduced if preventive services for teenagers were increased.

The services that would be mandated by S-2910 are laudable as a first step in confronting the critical problem of teenage pregnancies. However, we do have some specific comments and concerns as to how the objective of expanded medical, support, and preventive services would be achieved through the enactment of S-2910 in its present form.

The proposed legislation suggests the mobilization and coordination of existing national, regional, state and local resources to achieve a significant impact on the incidence of adolescent pregnancies nationally. The Forum agrees that better coordination of existing services is necessary if improved results are to be achieved. Yet, it's apparent that improved coordination of existing services, in itself, is not the solution.

The bill appears to presume that adequate existing resources currently are meeting the problem. In fact, this is not the case and at present, services available for the teenager are inadequate; in rural areas, the lack of services is especially acute, where the percentage of teens in need of services is at least 20 percent greater than the percentage of those served. Therefore, we recommend that 75 percent rather than 50 percent of program funds in S-2910 be designated for the initiation of new services, i.e., medical, support, preventive services, and for the expansion of existing services. The emphasis of the bill should be placed upon services--it's vital that the legislation reach beyond the limited services that now exist for teenagers.

The Forum is also concerned that the educational and counseling components as provided for teens in S-2910 be of a non-judgmental nature with adequate emphasis on prevention, options, and support services, e.g., day care. We do not feel it is appropriate for federally funded programs to impose moral positions on recipients of services. If non-judgmental counseling is not available, the effectiveness of a nationally coordinated effort to alleviate the crisis of teenage pregnancies would be crippled.

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In order to adequately address the enormous and complex problem of teenage pregnancies - estimated at 1 million young women in the United States each year - certainly more funds than those requested in S-2910 need to be committed. We do recognize there are limited resources available, however; consequently, we recommend that additional monies be allocated in each successive year of the program. We suggest that the initial authorization of $60 million be followed by authorization of $90 million and $120 million in the second and third years of the program respectively. In addition, we support the extension of the program over a three-year period--a shorter time frame would clearly be insufficient in tackling such a massive problem with any real results.

There is a need for a bill like S-2910. If these recommendations are adopted, we can ensure a serious and comprehensive effort to cope with the problem and if the constructive changes in content offered in the testimony here today are incorporated, a great step toward alleviating the problem of teenage pregancies in our nation will have been taken.

Thank you for the opportunity to testify today.

Senator RIEGLE. Let me now call, if I may, our last three witnesses for the day, Dr. Wendy Baldwin, Dr. Kristin A. Moore, and Ms. Janet Forbush.

Do you have a preference as to who goes first?

STATEMENT OF WENDY H. BALDWIN, Ph. D., SOCIAL DEMOGRAPHER, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NATIONAL INSTITUTES OF HEALTH; KRISTIN A. MOORE, Ph. D., RESEARCH ASSOCIATE, URBAN INSTITUTE, WASHINGTON, D.C.; AND JANET BELL FORBUSH, EXECUTIVE DIRECTOR, NATIONAL ALLIANCE CONCERNED WITH SCHOOL-AGE PARENTS, A PANEL

Dr. BALDWIN. It might be helpful if I went first.

Senator RIEGLE. If you would identify yourself for the record and to the extent that you can summarize, we will make your entire statements, part of the record.

Dr. BALDWIN. I am Dr. Wendy H. Baldwin, Social Demographer, Center for Population Research, NICHD, NIH.

Senator RIEGLE. Let me ask you to pull that microphone a little closer to you so that everyone can hear. We have a most interested part of your constituency here, both in person and by camera.

Dr. BALDWIN. I am going to summarize my testimony on trends and make some speculations about the future magnitude of this problem.

At present the birth rate of teenagers is declining over the levels we saw in 1960. This does not mean, however, that the number of births is declining at the same rate. In 1976 we had approximately 571,000 births by women under the age of 20. This was only 6 percent lower than what we saw in 1961 when the birth rate was substantially higher.

The reason we have this phenomenon is that the post World War II babies are now passing through the adolescent years. Our population of adolescents has greatly increased, so that even the declining birth rates mean high number of births to adolescents. Now, as other witnesses will testify, the effects of an early birth are in most cases, more severe the younger the mother. Consequently, I will look at specifically girls who are mothers under the age of 18.

While we had fewer births in the 1976 than we had in 1961, we actually had more births by women under the age of 18. In 1961, there were 185,000. 1976, we say 227,000. If we look at out-of-wedlock births, the births that are most likely to involve societal support or help, we again see that whereas the number of births in 1976 was lower than the number in 1961, the number of out-of-wedlock births was higher. When we look at the girls under the age of 18, we see that the women under 18 had 50,000 out-of-wedlock births in 1961, and 128,000 in 1976.

Senator RIEGLE. So it is more than double? It has gone from 50,000 to 128,000, which is a substantial increase.

Dr. BALDWIN. Yes; I feel in some ways it masks the problem just to look at the overall births because there has been shifts in the distribution of these births in marriage or out of marriage or to a young teenager or older teenager.

Given that brief résumé of trends, I would like to look at some of the things we might expect in the future. Since the peak of the baby boom was in 1959, the largest birth cohort is now age 19. This means that in subsequent years we will have smaller numbers of adolescents. As I indicated in my full testimony, the birth rate to adolescents is declining. Now, one might conclude, therefore, that teenage child bearing is going to become less important in the coming years. I do not think this is the case for the following reasons:

The younger adolescents—under age 18—is the one for whom a birth is most problematic. We see that the birth rates for the younger adolescents are still at some of the highest rates ever recorded, much more than we saw in the sixties. And their recent declines have been slight. Rates could easily move upward again as they did in the period 1971 to 1973.

Second, although their numbers are decreasing, there is still a large number of adolescents, and this means that even with low birth rates, we will have a large number of babies born to young adolescent mothers. If we are concerned with the children and family then the number, not just the rates, is important. The peak of the baby boom was like the crest of a slow wave. We will have larger than average numbers of adolescents for many years to come.

The trend has been for increasing proportions of births to adolescents, especially to young adolescents, to occur outside marriage. Out-of-wedlock births are more likely to require Government-sponsored services. This is especially true for the youngest adolescents, and it means an increase in the type of birth in which there is most likely to be societal involvement.

Fourth, adolescents are responsible for one-third of the over 1 million legal-induced abortions performed in 1976. A pregnant woman under the age of 15 was more likely to have an abortion than a birth. The changing status of abortion funding may result in reduced access to this method of fertility control, and the effects of this are not entirely clear.

Fifth, the extent to which adolescents are sexually active and the change over time has been addressed by researchers at Johns Hopkins University. Overall, in 1976, 36 percent of the unmarried women, age 15 to 19, were sexually active. The trend is toward more adolescents to be active and for them to be active at younger ages. The Johns Hopkins study shows that between 1971 and 1976, the increase in the proportion of unmarried adolescent women who were sexually active was 30 percent for 15-year-olds, 20 percent for 16-year-olds, and 54 percent for 17-year-olds.

Now, the expected decrease in population of adolescents, age 14 to 17, is less than 7 percent in the next few years. Consequently, if the trends in adolescent sexual activity were to continue—and we have no reason to think that it will not—the decline in the total number of adolescents could be matched with an increase in the number sexually active and in need of services.

The final reason for concern about adolescent fertility is that most adolescent pregnancies are unplanned and, in many cases, unwanted. The younger the women, the higher the chances that the pregnancy will result in an abortion or an out-of-wedlock birth. The Johns Hop-

kins study shows that only 23 percent of the unmarried teenagers said they intended to become pregnant. A study in New York City by Dr. Harriet Presser showed that at the time of their first birth, 48 percent of the women aged 14 to 19 said they wished they either had not had the baby or had the baby later. If you follow these girls for a couple of years, you find that 70 percent said if I had it to do over again, I would prefer to have had the baby later. So, the adolescents themselves, as we heard from the teenagers this morning perceive the problems with early childbearing.

In summary, most of the problems associated with teenage childbearing relate to births to women under age 18. For these adolescents, birth rates are still high, increasing numbers of births are out of wedlock, control of fertility is still poor and the exposure to risk is increasing. Consequently, I think the data on trends indicates that the problem of adolescent childbearing is one that is going to be with us for a number of years.

Thank you.

Senator RIEGLE. Thank you.

[The prepared statement of Dr. Baldwin and material referred to follows:]

TO BE RELEASED UPON DELIVERY ONLY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH
BETHESDA, MARYLAND 20014

STATEMENT BY

WENDY H. BALDWIN, Ph.D.
SOCIAL DEMOGRAPHER
BEHAVIORAL SCIENCES BRANCH
CENTER FOR POPULATION RESEARCH
NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

ON

TRENDS IN ADOLESCENT PREGNANCY AND CHILDBEARING

BEFORE THE

SENATE HUMAN RESOURCES COMMITTEE
UNITED STATES SENATE

JUNE 14, 1978

Introduction - This testimony is intended to provide background concerning patterns of adolescent reproduction.

Number of Births

The number of births to teenagers in 1976 was 4 percent below the number in 1975 (594,880). It is still a large number of births, only slightly lower than the 609,000 observed in 1961. This high number of births in the face of declining birth rates is one of the long term effects of the post World War II baby boom which has drastically increased the number of adolescents in today's society.

Other witnesses will testify as to the health and social consequences of early childbearing and show, for the most part, that the effects are more severe the younger the mother. The births in 1976 were distributed by age as follows: 12,000 to women under age 15; 215,000 to women 15-17; and 343,000 to women age 18 and 19. While the total number of births to teenagers is not much different than in 1961, the age distribution of the mothers is younger. In 1961 there were 7400 births to women under age 15; 178,000 to women 15-17; and 424,000 to women 18 and 19. To look only at the total number of births masks important changes in the age distribution of mothers. I do not mean to imply that the 18- or 19-year-old woman has no problems in regard to reproduction, but only that hers are less severe than those of the younger teenager.

Birth Rates to Teenagers

Not surprisingly, given the numbers presented above, the birth rates for older teenagers have fallen, although not as fast as those for adult women, whereas the birth rates for younger teenagers have risen. While currently showing a decline, the rates for women under 18 are still at some of the highest levels ever observed for the United States.

TABLE 1

Births per 1,000 Women 14-19 Years of Age, by Single Years of Age, for All Women: United States, 1920-1975
(highest rates underlined.)

Period	14	15	16	17	18	19
1920-24	3.6	11.9	28.6	57.9	93.1	125.4
1925-29	3.9	12.3	28.5	55.6	86.9	114.0
1930-34	3.4	10.9	25.2	48.6	75.3	99.0
1935-39	3.7	11.5	26.0	49.0	75.0	97.9
1940-44	4.0	12.7	27.8	52.2	81.7	109.2
1945-49	4.9	15.5	34.1	63.7	99.4	133.0
1950-54	5.9	19.3	43.1	79.7	123.1	162.6
1955-59	6.0	20.1	45.7	85.8	136.2	184.0
1960-64	5.4	17.8	40.2	75.8	122.7	169.2
1965	5.2	16.5	36.0	66.4	105.4	142.4
1966	5.3	16.4	35.5	64.8	101.8	136.1
1967	5.3	16.5	35.3	63.2	97.5	129.5
1968	5.7	16.7	35.2	62.6	95.7	125.2
1969	6.0	17.4	35.8	63.1	95.7	124.5
1970	6.6	19.2	38.8	66.6	98.3	126.0
1971	6.7	19.2	38.3	64.2	92.4	116.1
1972	7.1	20.1	39.3	63.5	87.1	105.0
1973	7.4	20.2	38.4	61.5	83.1	98.5
1974	7.2	19.7	37.7	59.7	80.5	96.2
1975	7.1	19.4	36.4	57.3	77.5	92.7
1976	6.8	18.6	34.6	54.2	73.3	88.7
Percent decline from highest rate to 1976	8%	8%	24%	37%	46%	52%

Source: 1920-73: National Center for Health Statistics, Fertility Tables for Birth Cohorts by Color: United States, 1917-73 DHEW Publication No. (HRA) 76-1152, U.S. Government Printing Office, 1976, p. 137

1974-1976: National Center for Health Statistics, Unpublished tabulations.

Marital Status of the Mother

Since marital status of the mother influences the extent to which a child and its mother will receive social support, it is useful to look at the illegitimacy rate and the number of out-of-wedlock births to adolescents (see Table 2). Whereas older women have generally reduced their illegitimacy rates (number of out-of-wedlock births per 1000 unmarried women) this is not the case for adolescents. Their illegitimacy rates are close to the highest ever observed in this country and the percent of out-of-wedlock births that occur to teenagers has generally increased over the years, currently standing at over 50 percent.

In 1976 there were 235,300 out-of-wedlock births to women under age 20 -- 10,300 to women under age 15 and 116,500 to women 15-17. This is a considerable increase over 1961, when women under 15 had 5200 out-of-wedlock births and women 15-17 had 45,000 out-of-wedlock births.

A Look to the Future

The number of births is, of course, a function of the number of young women and their fertility rate. As previously noted, the U.S. has had an abundance of teenagers as a result of the post World-War-II baby boom. The largest birth cohort was aged 19 in 1976 and since succeeding birth cohorts were smaller, there will be fewer adolescents in coming years. Between 1976 and 1980 we can expect the number of 14-17 year olds to decrease by 6.7%. If the proportion of those who are sexually active continues to increase, however, the net effect may well be an increase in the absolute number of adolescents at risk of pregnancy.

Table 2

Out of Wedlock childbearing - 1960, 1970 & 1976

	1960	1970	1976
Total number of births	4,257,850	3,731,386	3,167,788
Total number out-of-wedlock births	224,300	398,700	468,000
Number out-of-wedlock births to women under 20	91,700	199,900	235,300
Percent out-of-wedlock births to women under 20	40.9	50.1	50.2
Number out-of-wedlock births ages 18-19	43,400	94,300	108,500
Number out-of-wedlock births ages 15-17	43,700	96,100	116,500
Number out-of-wedlock births under 15	4,600	9,500	10,300
Illegitimacy rate, women 15-19	15.3	22.4	24.0
Illegitimacy rate, women 20-24	39.7	38.4	32.2

Sources: National Center for Health Statistics, Monthly Vital Statistics Report, "Final Natality Statistics, 1970," Vol. 22 No. 12 Supplement, March 20, 1974;
National Center for Health Statistics, Monthly Vital Statistics Report, "Final Natality Statistics, 1976," Vol. 26 No. 12 Supplement March 29, 1978
"National Center for Health Statistics, "Trends in Illegitimacy - United States 1940-1965". Vital & Health Statistics, Series 21 No. 15, Oct. 1968.

Table 3

Percent Unmarried Women Experiencing Sexual Intercourse, 1971 and 1976

	1976	1971	Percent Increase
15-19	36.9	26.8	30.2
15	18.0	13.8	30.4
16	25.4	21.2	19.8
17	40.9	26.6	53.8
18	45.2	36.8	22.8
19	55.2	46.8	17.9

Source: Melvin Zelnik & John F. Kantner, "Sexual & Contraceptive Experience of Young Unwanted Women" Family Planning Perspectives Vol. 9 No. 2 March/April 1977

Kantner and Zelnik note an increase from 1971 to 1976 in the percent of unmarried women 15-19 who have experienced coitus, as seen in Table 3. While the number of young adolescents will decline slightly in the coming years it is possible that the number of sexually active adolescents will actually increase.

On the one hand the birth rates for adolescents are declining, as are the number of adolescents projected for future years. On the other hand several factors already challenge against the conclusion that teenage reproduction is not a cause for concern.

1. The birth rates for adolescents (under 18) have declined very little from all-time highs and showed increases from 1971 to 1973. Birth rates--especially for the young adolescents--are still disturbingly high.

2. Even with declining rates there are, and will continue to be, large numbers of babies born to young adolescent mothers. The peak of the baby boom was the crest of a slow wave; we will have larger than average numbers of adolescents for many years to come.

3. The trend has been for increasing proportions of births to adolescents--especially to young adolescents--to occur outside marriage. Out-of-wedlock births are more likely to require government-sponsored services. The growth in out-of-wedlock births to women under 18 has been from 48,300 in 1960 to 105,600 in 1970 to 126,800 in 1976.

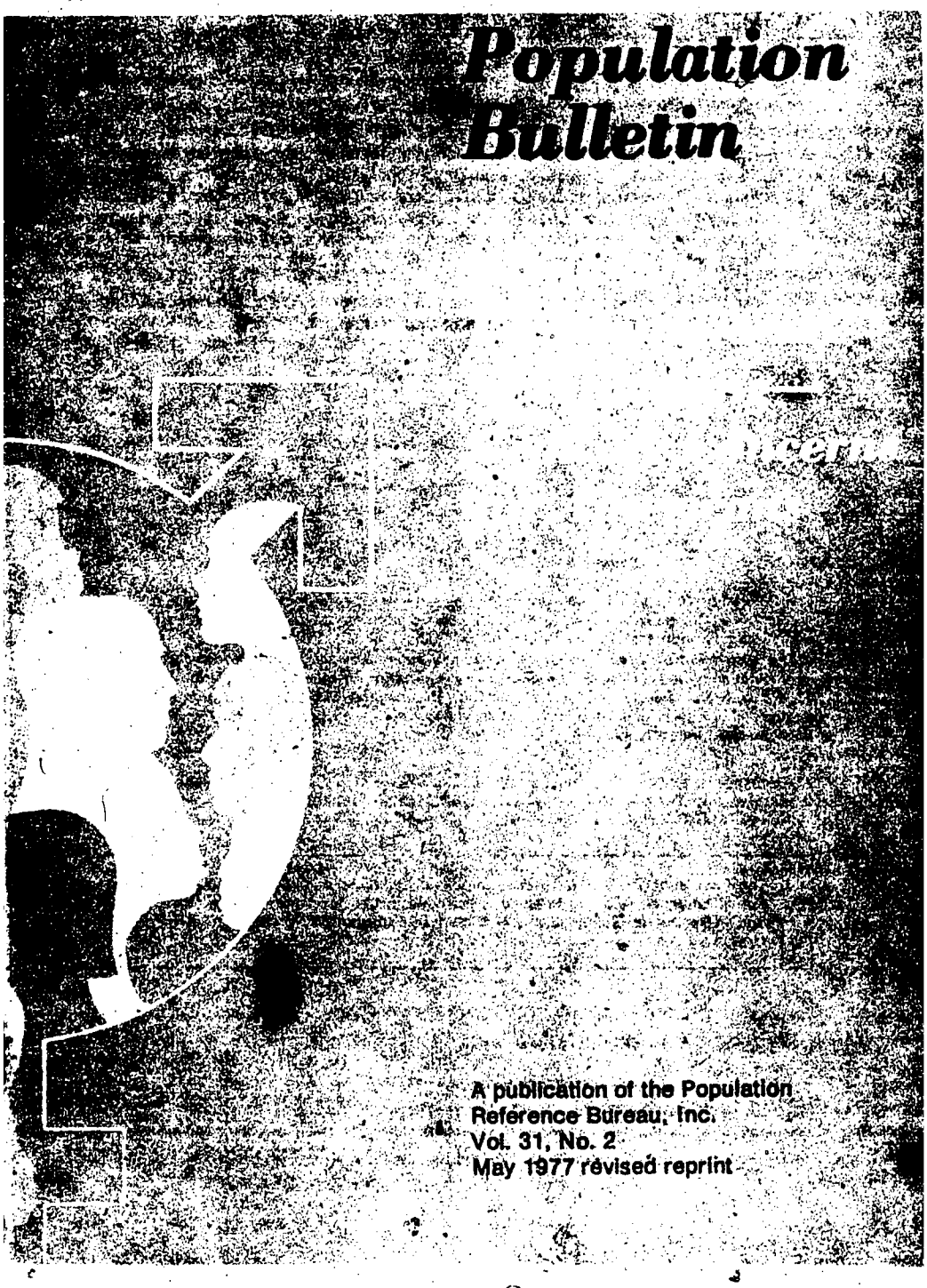
4. The number of legal abortions continues to increase and teenagers continue to account for one-third of the total. In 1976 women under age 20 received 370,000 abortions--over 15,000 of them to women under age 15. The changing status of abortion funding may reduce adolescents' access to this form of fertility control. The extent to which this would result in increased births and/or use of "cut-rate" abortions is not clear.

5. While the number of adolescents will decline slightly in coming years, in all likelihood the number of sexually active adolescents will not decrease and may actually increase.

And a final reason for concern about teenage fertility is that for most young adolescents, pregnancies are unplanned and/or unwanted. The younger the woman, the higher the chances a pregnancy will end in an abortion or an out-of-wedlock birth. The Johns Hopkins study shows that only 23% of the unmarried teenagers say they intended to become pregnant. A study in New York City by Dr. Harriet Presser showed 44% of the 15-19-year old new mothers regretted the timing of their birth and would have preferred to have had it later.

In summary, most of the problems associated with teenage childbearing relate to births to women under age 18. For these adolescents birth rates are still high, increasing numbers of births are out-of-wedlock, control of fertility is still poor, and the exposure to risk is increasing.

With your permission I should like to enter into the record a booklet I prepared for the Population Reference Bureau on this topic.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Adolescent Pregnancy and Childbearing—Growing Concerns for Americans

Abstract—With their numbers swollen by the postwar baby boom to a record 20 million plus, adolescent women in the United States now account for nearly 20 percent of annual births, over half of illegitimate births, and a third of annual abortions. Sexual activity among teenagers appears to be increasing while their marriage rates decline. This *Bulletin* examines the negative impact of these trends on society and the health and life chances of the women and children involved, documents the barriers to effective practice of contraception by teenagers, considers racial differences, and briefly relates the U.S. experience to that of other countries.

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Cover design by Phyllis Avedon—Charts by James O'Brien

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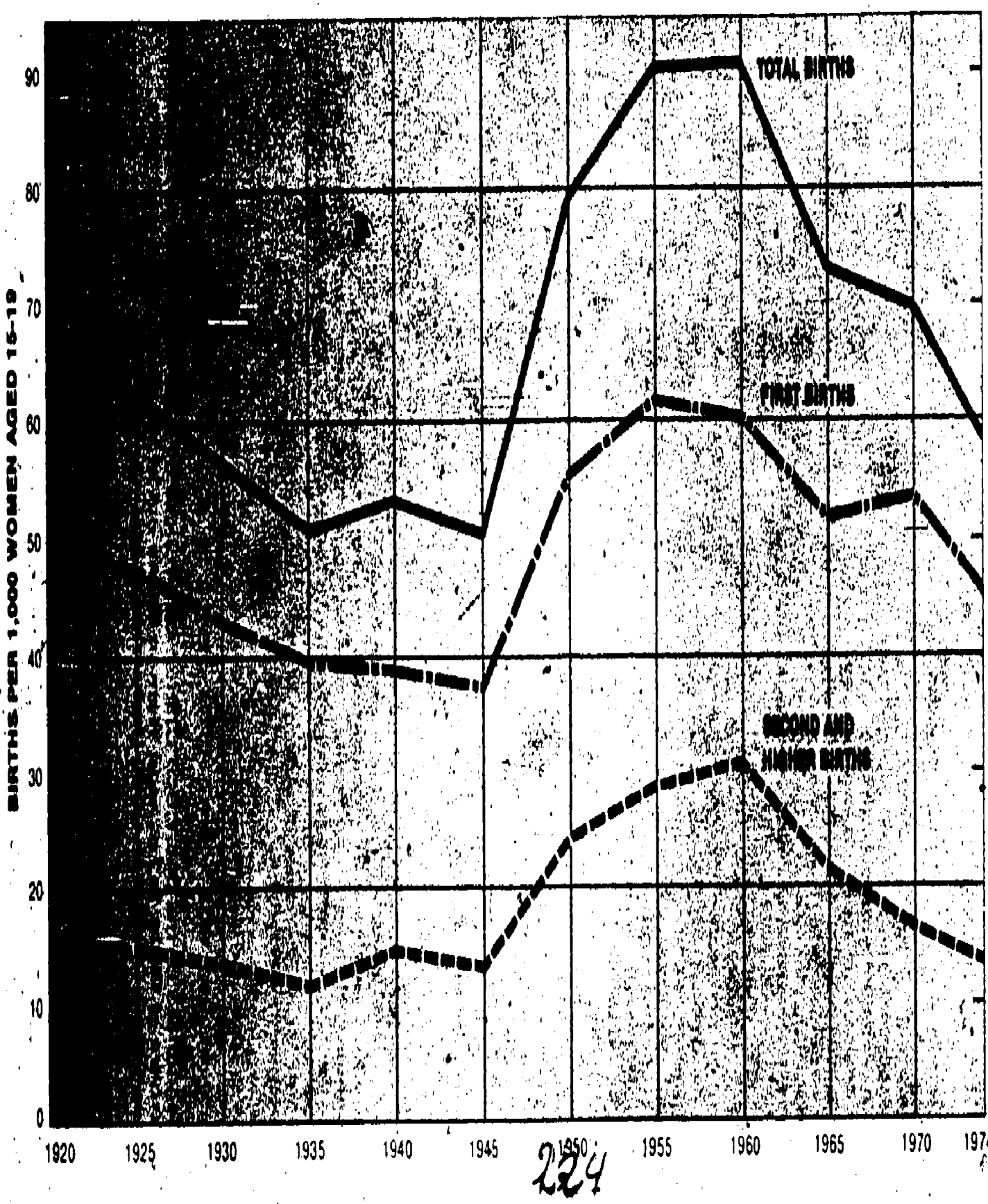
Figure 1. Fertility Rates of U.S. Women Aged 15-19: 1920-1974



Sources: National Center for Health Statistics, *Fertility Tables for Birth Cohorts by Color: United States, 1917-1973* (U.S. Government Printing Office, 1976) Table 3A; advance [illegible] plied by Robert L. Heuser, Chief, Natality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics.

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Adolescent Pregnancy and Childbearing—Growing Concerns for Americans

By **Wendy H. Baldwin**

Dr. Baldwin is a social demographer on the staff of the Behavioral Sciences Branch of the Center for Population Research, National Institute of Child Health and Human Development, National Institutes of Health, which administers a contract research program in the behavioral sciences. She monitors a research program which includes studies of the consequences of adolescent pregnancy and childbearing, and has chaired a conference on the determinants of adolescent pregnancy and childbearing. Dr. Baldwin was a participant in the First Inter-Hemispheric Conference on Adolescent Fertility, held at Airlie House, Warrenton, Va., August 31-September 4, 1976. She has a Ph.D. in sociology with a minor in demography from the University of Kentucky and worked with the Colombian National Fertility Survey, 1969. Her doctoral dissertation based on that survey has been published in Spanish by the Colombian Association of Medical Faculties (ASCOFAME). She has also reported on this research in Studies in Family Planning.

Pregnancy and childbearing among teenagers is currently of growing interest and concern in the United States. Newspaper stories decry "Kids Having Kids" and official statistics show a dramatic rise in illegitimate births to young mothers. Are these concerns realistic? What is happening with teenagers today regarding fertility, contraception and sex, and how does it differ from the past?

Presently, there are over 20 million American women between the ages of 10 and 19, almost equal to the population of Canada. These products of the postwar baby boom add up to the largest number of adolescent women the United States has ever had at one time. According to one survey, over a quarter of the young women aged 15 to 19 are sexually active and thus have enormous potential for contributing to our country's growth.

In this *Bulletin* we will look at current patterns, changes over time, sexual behavior, contraceptive practices, abortion, and childbearing among these adolescents, and briefly compare the U.S. experience to the situation in other developed nations. When possible this picture of adolescent fertility-related behavior will separate births occurring within marriage and those borne out of wedlock, look at differences by age of the women involved, and review differences between racial groups. Since most of the relevant statistics are gathered with the woman as the focus, the information on men is scarce, but this too will be presented wherever possible.

Overall Fertility Rates Among Teenagers

Contrary to what may be the general impression, overall rates of childbearing among U.S. teenagers have actually fallen in recent years, from a high of 97.3 births per 1,000 women aged 15 to

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19 in 1957 to 58.7 in 1974. The drop amounted to more than a third between 1960 and 1974. This substantial decline, however, has not been as extreme as that experienced by older women. From 1960 to 1974 rates fell by 54 percent among women aged 20 to 24 and 43 percent among those aged 25 to 29. The difference means that births to teenagers now figure more prominently among all births—up from 14 percent of the total in 1960 to nearly one in five (19 percent) in 1974.

A decreasing birth rate does not necessarily mean decreasing numbers of births. While teenage birth rates turned down from 1960 to 1974, the number of women aged 10 to 19 swelled from around 15 million to over 20 million and the annual total of births stayed about the same, dropping only from 609,000 to 608,000 (12,529 to women under 15 and 595,449 to women aged 15 to 19). We can see that even with the substantial decline in fertility rates for teenagers the problem in terms of numbers of women, children and others affected has hardly changed at all.[1]

The long view

Comparing current birth rates with the rates for 1960 is somewhat problematic because 1960 was an era of very high teenage fertility rates. If we step back and take a longer perspective we see that fertility rates for women aged 15 to 19 declined from at least 1920 until the period 1935-1945 and then began to rise. After peaking in the late 1950s the rates started to fall for teenagers, as for all women in the United States. These patterns are similar for first births and for second and higher order births, although the swings have been more erratic for the latter, as can be seen in Fig. 1 on page 2.

Age differences

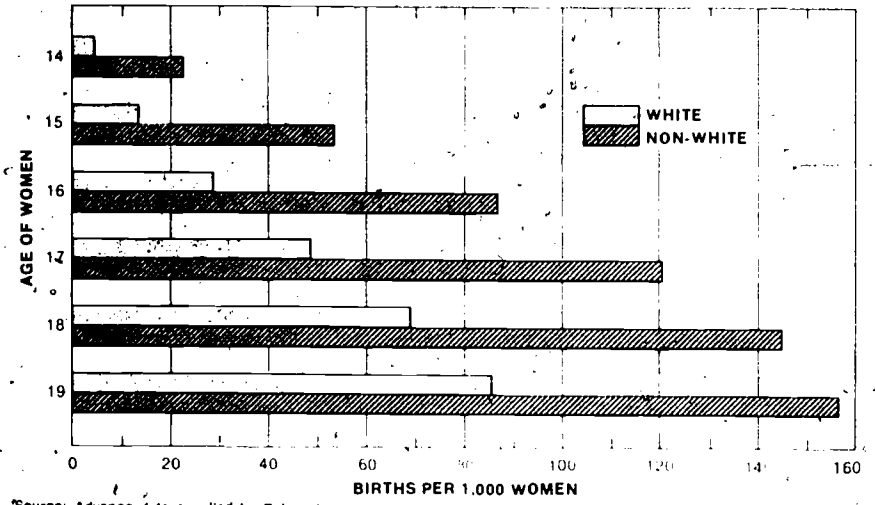
To group all teenage mothers together is also misleading since fertility rates and trends vary for teenage women at different ages. Table 1 shows the rates for 14- to 19-year-old women by single year of age and by year of birth back to 1910, so we can see the change over time. The first row is for women born in 1955 and therefore age 14 in 1969; the second row is for women born in 1950 who were age 14 in 1964, and so forth. Women born in 1940 had the highest fertility at each age. Rates at all ages have declined from that peak since then. However, the most recent birth experiences show rates rising again for the very young girls, while continuing to fall for the older teens.

Table 1. Long-Term Trends in Birth Rates among U.S. Teenagers, by Single Year of Age and Year of Birth

Year of birth	Births per 1,000 women at age					
	14	15	16	17	18	19
1955	6.0	19.2	38.3	63.5	83.1	96.2
1950	5.2	16.5	35.5	63.2	95.7	124.5
1940	6.3	19.9	46.8	89.3	138.1	187.6
1930	3.8	11.8	28.6	70.3	113.8	150.2
1920	3.4	11.3	25.0	49.8	78.1	98.8
1910	3.7	12.4	28.7	56.5	83.8	105.3

Sources: National Center for Health Statistics, *Fertility Tables for Birth Cohorts by Color: United States, 1917-1973* (U.S. Government Printing Office, 1976) Table 4A; Robert L. Heuser, Chief, Natality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics, personal communication

Figure 2. Birth Rates of U.S. Teenage Women by Age and Race: 1974



Source: Advance data supplied by Robert L. Heuser, Chief, Natality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics.

In the five years from 1970 to 1974 births for 14-year-olds climbed 9 percent from 6.6 to 7.2 per 1,000 and 3 percent for 15-year-olds (19.2 to 19.7). Meanwhile the rate eased down a further 3 percent to 37.7 per 1,000 for 16-year-olds. For 17-, 18-, and 19-year olds there were sharp drops of 11, 18 and 24 percent respectively, their rates being 59.7, 80.5 and 96.2 in 1974.[2] It is disturbing that the rates are rising fastest for girls least able to care for a baby. Girls under the age of 15 bore almost 13,000 babies in 1974.[3]

Each recorded birth is the end result of a chain of events which occur with varying amounts of knowledge, understanding of the consequences, or conscious decision-making. The factors that influence entry into sexual activity, the use of contraceptives, and the decision to seek an abortion may all be quite different for the 14-year-old than for the 18-year-old. Adolescence is a period of rapid change for the individual and not the least of those changes involves dealing with puberty, including one's own growing sexual awareness, and changing interpersonal and social pressures. These differences by age influence not only the factors leading up to a birth, but also the consequences of that birth. As we shall see, one major difference between younger and older teenagers relates to the propensity to marry.

Racial comparisons

As seen in Fig. 2, teenage fertility is higher for nonwhites than for whites. The birth rates for single years of age illustrate the extreme racial differences in childbearing for young adolescents. For girls aged under 14 the nonwhite rate is five times that of whites, but among 19-year-olds, the nonwhite rate is less than twice the white rate.

A comparison of rates by single year of age for the past five years shows an interesting difference by race. For girls

Table 2. Percent Change in Teenage Birth Rates by Race and Single Year of Age: 1970-1974

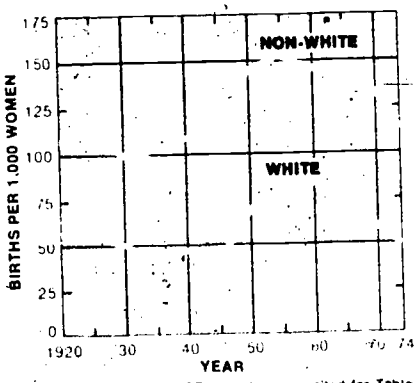
Race	Age 14	15	16	17	18	19
White	+ 19	+ 7	0	— 10	— 19	— 25
Nonwhite	— 4	— 8	— 10	— 14	— 18	— 21

Sources: National Center for Health Statistics, *Fertility Tables for Birth Cohorts by Color: United States, 1917-1973* (U.S. Government Printing Office, 1976) Tables 4B and 4C; Robert L. Heuser, Chief, Natality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics, personal communication.

over age 16 birth rates are falling for both groups at about the same rate. Rates for 16-year-olds have been stable among white girls while declining 10 percent among nonwhites. The real differences comes in the young teens where black rates are falling and white rates are increasing (Table 2).

It is far too early to conclude that the rates are converging because they are still quite different in magnitude. Fertility rates for white teenagers have been very low and traditionally quite high for their nonwhite counterparts. This difference in recent trends is intriguing given that generally they have followed the same patterns as seen in Fig. 3.

Figure 3. Fertility Rates of U.S. Women Aged 15-19 by Race: 1920-1974



Sources: Tables 3B and 3C in first source cited for Table 2 (above), and Robert L. Heuser, op. cit.

Since blacks make up about 92 percent of the U.S. nonwhite population at most ages, it can be speculated that the disparity between nonwhite and white teenage fertility rates is influenced by the greater sexual activity at younger ages of black girls and possibly the earlier maturation of their reproductive systems. By age 11, 21 percent of black girls are menstruating, compared to only 11 percent of whites. This racial difference at menarche is found within categories of income and place of residence, and in all geographic regions except the South, reports the National Center for Health Statistics. Whites catch up by age 13, when three-fourths of all girls are menstruating.[4]

Obviously, there are differences in personal, social and cultural factors which affect the behavior of black and white girls and therefore influence birth rates. However, it is important to note the similarities in fertility patterns between these groups—similarities which probably reflect common reactions to broad forces that operate in our society. Both racial groups have recorded considerable declines in the birth rates for the older teenagers.

Legitimate and Illegitimate Births

While closer inspection reveals that recent shifts in *overall* teenage child-

bearing have perhaps not been so startling as is sometimes supposed, there have indeed been disturbing changes in illegitimacy among young U.S. women. From 1960 to 1974, the illegitimacy rate (number of births per 1,000 unmarried women) declined for all age groups over 20, but increased by 52 percent for women aged 15 to 19 (Table 3). In actual numbers, out-of-wedlock births to teenagers have more than doubled, from 92,000 in 1960 to 221,400 in 1974 —10,600 to women under 15 and 210,800 to women aged 15 to 19. Meanwhile, legitimate births fell for this age group, as for all American women—from an annual 511,000 to 387,000 over the same period. Thus, illegitimacy is becoming increasingly concentrated in the teenage years. Over half (53 percent) of the 1974 total of 418,100 illegitimate births in the United States occurred to teenage mothers.[5]

Age differences in teenage illegitimacy

As is true for overall fertility, illegitimacy among teenagers varies markedly by age. The majority of births to teenagers as a whole still occur within marriage, although a substantial proportion of these are conceived outside of marriage. As might be expected, older teenagers are far more likely to be married when their babies are born than are the younger teens. In 1974, less than a quarter (23 percent) of births to 19-year-olds were out of wedlock, compared to 85 percent of those to girls under the age of 15. It is unlikely that a girl under 15 would be able to carry out the roles of wife and mother even if she has carried a pregnancy to term. One might also speculate that the boys these girls are involved with are unprepared to assume the roles of husband and father. In fact, in cases where data are available, 72 percent of fathers of babies born to women under 15 are themselves in their teens.[6]

Table 4 on the next page further illustrates some of these points. From 1960 to 1974, the proportion of teenage births occurring out of wedlock jumped from 15 to 36 percent, with the rise shared by all age groups. The very large increases among 18- and 19-year-olds should be interpreted with caution, however. Their proportions of illegitimate births were lowest in 1960 and hence had the greatest potential for increase.

Racial similarities and differences

Again, as with overall birth rates there are similarities and differences in patterns of illegitimacy for white and nonwhite teenagers. For both groups the proportion of children born out of wedlock is up since 1960, but remains much

Table 3. Illegitimate Births per 1,000 Unmarried Women by Age: 1960 and 1974

Year	Ages 15-19	20-24	25-29	30-34	35-39	40-44
1960	15.3	39.7	45.1	27.8	14.1	3.6
1974	23.2	30.9	28.4	18.6	10.0	2.6
Percent change 1960-1974	+ 52	— 22	— 37	— 33	— 29	— 28

Sources: National Center for Health Statistics, "Trends in Illegitimacy: United States 1940-1965," *Vital and Health Statistics*, Series 21, No. 15 (February 1968) Table 1. National Center for Health Statistics, "Advance Report: Final Natality Statistics 1974," *Monthly Vital Statistics Report*, Vol. 24, No. 11, Supplement 2 (February 13, 1976) Table 11

Table 4. Percent of Births to Teenage Women Borne out of Wedlock: 1960 and 1974

Year	Age of Mother			
	Under 15	15-17	18-19	All under 20
1960	68	24	11	15
1974	85	48	27	36
Percent change 1960-1974	+25	+100	+145	+140

Sources: National Center for Health Statistics, "Trends in Illegitimacy, United States 1940-1965," *Vital and Health Statistics*, Series 21, No. 15 (February 1968) Table 9; National Center for Health Statistics, "Advance Natality Statistics 1974," *Monthly Vital Statistics Report*, Vol. 24, No. 11, Supplement 2 (February 13, 1976) Table 11.

higher for nonwhites than whites. In 1974 this proportion was 21 percent for all white teenagers and 73 percent for their nonwhite counterparts. Both groups also show highest proportions of out-of-wedlock births among the youngest teenagers. Numbers of births per 1,000 unmarried women (illegitimacy rates) also registered a similar dramatic increase for both white and nonwhite teenagers between 1960 and 1974. Again, rates for nonwhites continue at a level far above those of whites (Table 5).

Out-of-Wedlock Conceptions and Births

There are actually three categories of births of interest in regard to teenage fertility. Some births are conceived in marriage; others are conceived outside of marriage but occur within marriage; and still others are both conceived and delivered out of wedlock. Arthur A. Campbell has made estimates for the periods 1960-1964 and 1970-1974 to show how these three groups of births to teenagers have changed. He found that the proportion of births that were conceived out of wedlock remained at about 50 percent in both time periods. The proportion that were actually born out of wedlock, however, increased substantially. Conversely, the percent of out-of-wedlock conceptions "legitimized" by marriage has fallen from approximately 65 to 35 percent in this brief period.[7]

The pattern seems clear. The dramatic rise in illegitimate births to teenagers has not occurred because of more out-of-wedlock conceptions, but because fewer out-of-wedlock conceptions now lead to marriage. This means our search for explanations of the increase in numbers of illegitimate births should center on changing teenage behavior with regard to marriage.

Why have U.S. teenagers apparently become so much less inclined to select marriage as a solution to an out-of-wedlock pregnancy? Young women could be more willing to place their

Table 5. Illegitimate Births per 1,000 Unmarried Women Aged 15-19, by Race: 1960 and 1974

	Total	White	Nonwhite
1960	15.3	6.6	76.5
1974	23.2	11.1	88.8

Sources: National Center for Health Statistics, "Trends in Illegitimacy, United States 1940-1965," *Vital and Health Statistics*, Series 21, No. 15 (February 1968) Table 2; National Center for Health Statistics, "Advance Natality Statistics 1974," *Monthly Vital Statistics Report*, Vol. 24, No. 11, Supplement 2 (February 13, 1976) Table 11.

children for adoption, more interested in raising the child themselves, or young men could be less willing to assume the responsibility of marrying or less susceptible to the pressures that forced the couple to marry in the past. High unemployment among both young men and women could make setting up housekeeping seem unrealistic or the Aid to Families with Dependent Children program could make raising a child alone economically feasible.

A study of first-time mothers in New York City found that over half of those who had borne their child out-of-wedlock did not want to marry the father, although some still saw the man. Their reasons reflected a thoughtful assessment of the roles of father and husband and the conclusion that the man involved could not fulfill them. He may have been an alcoholic, a drug user, in jail, or irresponsible. Marrying him could have resulted in more problems than another solution to an untimely pregnancy. Most of these women, however, did want to marry eventually.[8]

Let us take a look at changing teenage marriage patterns.

Marriage Among Teenagers

While high rates of illegitimacy and marital disruption receive much attention from both the media and social scientists, the fact remains that Americans are very marriage-prone. Of women aged 35 to 39 in 1970, 95 percent were currently, or had been, married, and the comparable figure for men was 93 percent.[9] About 37 percent of this group of women had married by the age of 19. By contrast less than a quarter (23 percent) of women aged 19 in 1970, were or had been married.[10]

A detailed measure of marriage behavior is the cumulative first marriage rate which shows the number of marriages at different ages per 1,000 women in a birth cohort, i.e., born during the same period, such as 1950-54. A time series of such rates reveals a striking change in marriage patterns among U.S. teenagers. Table 6 on the next page presents these rates by single year of age during the teenage years for women who were born between 1920 and 1954. The women born from 1950 to 1954 were teenagers in the late 1960s and early 1970s and can be compared with women born 1935-49 who were teenagers in the early 1950s. Rates of first marriage at 18 and under rose until the cohort of women born 1935-39, and then declined. The declines have been significant at all ages, but largest for the youngest girls.

Why the downturn in teenage marriages?

In 1967, Robert Parke and Paul Glick of the Census Bureau speculated on reasons for the general downturn in teenage marriage which became evident during the 1960s and hypothesized a "marriage squeeze." Because of the baby boom there has been an imbalance of men and women of marriageable age. Women generally marry men a few years older than themselves and the increasing size of cohorts that resulted from the baby boom meant that as the first members of the baby boom reached age 19 in 1965, for example, there were more women aged 19 (born in 1946) than men aged 21 or 22 (born in 1943 or 1944).[11] The baby boom peaked in 1957 after which the birth rate has maintained a downward trend. Thus young women entering the marriageable ages in 1977 or later years will find an excess of men several years older than themselves. This could prompt another shift toward more women marrying early.

But the availability of marriage partners is only one factor influencing marriage rates. The extent to which women are staying in school, going into college,

Table 6. Cumulative First Marriage Rates[a] among U.S. Teenage Women Born 1920-1954

Year of birth of women	Age at last birthday			
	15	16	17	18
1950-54	14	34	75	155
1945-49	26	52	101	193
1940-44	36	72	134	239
1935-39	43	83	151	262
Percent decline 1935-39/1950-54	— 67	— 59	— 50	— 41
1930-34	35	74	141	247
1925-29	36	65	117	203
1920-24	31	59	107	183

Source: U.S. Bureau of the Census, "Childspacing and Current Fertility," *Subject Reports*, PC(2)-3B (U.S. Government Printing Office, 1975) Table 1.

[a]Number of ever-married women per 1,000 women.

or even graduate school has increased. Coupled with increased labor force participation of women, this suggests that fewer women may now feel obligated to marry as soon as possible for lack of an alternative, socially acceptable role.[12] As for young men, continued employment uncertainties may make them less willing to commit themselves to marriage.

The apparent upturn in numbers of young couples living together either before marriage or in place of marriage may also continue. Paul Glick has reported that "compared to 1960, 50 times as many men and more than 16 times as many women age 18-24 reported in 1970 that they shared their living quarters with an unrelated partner of the opposite sex," and that the number of such households was 82,000 in 1970. Furthermore, this number increased as much between 1970 and 1974 as it did between 1960 and 1970.[13] Many such couples, even among the teenagers, may regard their situation as quite marriage-like, but this, of course is not reflected in official marriage statistics.

Adoption

One alternative to raising a child is placing the baby for adoption. Much has appeared in the media about the shortage of babies for adoption and one supposition is that more unwed mothers are now keeping their babies. We have just seen that fewer out-of-wedlock conceptions among teenagers now lead to marriage, but what do we know about adoptions?

Statistics on adoptions are collected by the Social and Rehabilitation Service, National Center for Social Statistics, but their reporting by states is voluntary and is thus incomplete. Still, the data we do have on adoptions may shed some light on the ultimate resolution of illegitimate births. Of course, these two groups are not synonymous since not all babies born out of wedlock are placed for adoption, nor are all adopted babies the result of out-of-wedlock births.[14]

Figure 4 shows annual numbers of babies adopted and the number born out of wedlock from 1957 to 1973—a period with ever more illegitimate births

being attributed to teenage mothers. The two lines run in tandem until 1970, but the paths then diverge, with illegitimate births continuing to rise while the number of babies placed for adoption is turning down. If the proportion of illegitimate births placed for adoption had been constant through 1974 there should not have been the drop-off in adoptions since 1970. It does indeed appear that fewer mothers of babies born out of wedlock are relinquishing them for adoption.

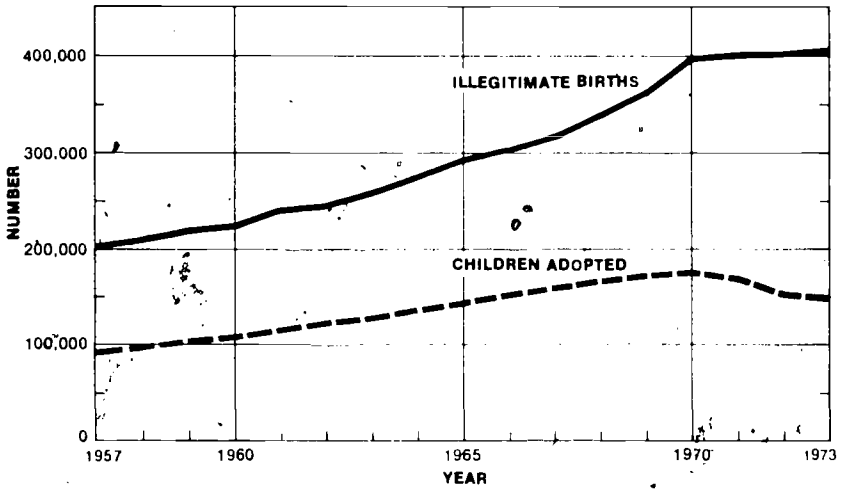
This finding is supported by information from adoption agencies which report a sharp decline in the number of unwed mothers seeking adoption for their babies. Testifying in the Senate hearings for the Mother and Child Health Bill in November 1975, Elizabeth Cole of the Child Welfare League stated that:

In adoption agencies about 5 years (ago), of all the mothers who came in asking for adoption services, approximately 80 percent would choose to place their children for adoption, and about 20 percent would choose to keep their children and raise them. That figure is reversed. The figure now is 80 to 90 percent of the mothers coming to the adoption agency choose to keep and raise their children, and only 10 to 20 percent place their children for adoption.[15]

It is interesting to note that, despite their historically high rates of teenage childbearing and illegitimacy, blacks have always had low rates of adoption. A baby born to a young black girl is much more likely to be raised by the mother and her family than is the case among whites. In 1973, nonwhites accounted for only 13 percent of adopted babies in contrast to 60 percent of all out-of-wedlock births.[16]

Of course, it is possible that in the past women bore out-of-wedlock babies because abortion was not easily obtainable. With legal abortion theoretically available across the nation since the Supreme Court decisions of January 1973, it may be that those women most highly

Figure 4. Numbers of Illegitimate Births and Adoptions in the United States: 1957-1973



Source: Gordon S. Bonham, "Who Adopts: The Relationship of Adoption and Social-Demographic Characteristics of Women," presented to the American Sociological Association meeting, New York, August-September, 1976; Table A.

motivated *not* to have a child are electing abortion rather than adoption.

The *Adoption Statistics Bulletin* for 1971 noted that the decrease in the number of adoptions from 1970 to 1971 —175,000 to 169,000—was attributable in large part to the decline by 4,800 in children placed for adoption in California.[17] Beth Berkov and June Sklar have analyzed the relationship of abortions to illegitimate births in California, one of the first states to liberalize abortion laws, and concluded that "there is good evidence that legal abortion in California has helped reduce both legitimate and illegitimate fertility but especially illegitimate fertility."[18] While the data do not permit firm conclusions, it appears plausible that abortion has replaced adoption as a form of resolution for some out-of-wedlock pregnancies. For the 39 states where roughly comparable data were available there was a 36 percent decline in adoptions from 1971 to 1974, a period of increasing availability of legal abortion.

In short, the adoption market may be feeling the double effect of abortion now being available as an alternative to placing an out-of-wedlock baby for adoption plus the fact that more unwed mothers are evidently now opting to keep their babies.

Abortion as an Outlet?

Statistics do indeed confirm that many teenage pregnancies are now resolved through abortion. Approximately a third of the 763,476 legal abortions officially reported for 1974 to the Center for Disease Control in Atlanta were performed on women less than 20 years of age.[19] A nationwide survey of medical facilities by the Alan Guttmacher Institute of the Planned Parenthood Federation of America suggests that the true total of abortions in 1974 was close to 900,000.[20] If so, there may have been upwards of 300,000 abortions performed on teenage girls in that year. Both sources of information indicate that although the total number of legal abortions rose from 1972 to 1974, the proportion performed on adolescents remained stable.

There are few national data relating social characteristics to abortion characteristics but some information is available on age distribution of teenagers obtaining abortions. According to this, for girls under the age of 15 there are now more abortions than live births. In 1974, the abortion ratio for 15-year-olds (number of abortions per 1,000 live births) was 1,156.[21]

Risks for teenagers

Abortion is generally recognized as an essentially safe procedure, with only 1 percent of those performed legally in the United States resulting in a major complication. But there are different risks according to the gestational period in which the abortion is performed. Early abortions (before the 13th week of pregnancy) are almost all performed by curettage, and usually suction aspiration, which has the lowest rate of complications and death. Abortions performed at 13 to 15 weeks of gestation are divided between curettage and intrauterine instillations (generally saline) and involve increased risks for the women. Late abortions are usually instillations and have the highest rate of complications and mortality (Table 7).

While morbidity and mortality rates are strongly tied to type of procedure, the selection of procedure is largely governed by the length of gestation. Data from New York City show that teenagers are disproportionately represented among women receiving late abortions. Of the girls under the age of 15 who received abortions in New York City in 1974, 34 percent were past the 15th week of pregnancy as were 21 percent of those girls aged 15 to 19. Only

Table 7. Abortion Deaths by Time of Performance and Type of Procedure: United States, 1974.

	Deaths per 100,000 legal abortions
Gestational Period	
Early	
0-8 weeks	0.3
9-12 weeks	2.4
Middle	
13-15 weeks	11.8
Late	
16 weeks and over	16.9
Type of procedure	
Curettage suction	1.7
Curettage sharp	5.3
Instillation	15.2

Sources: U.S. Center for Disease Control. *Abortion Surveillance 1974* (April 1976). Tables 20 and 21

13 percent of the women over 35 were this far along in their pregnancies at the time of the abortion. Nonwhites were more likely to have late abortions at all ages, but the pattern of age of mother and gestational period was the same for whites and nonwhites.[22] Less experience with recognizing the symptoms of pregnancy, difficulty in resolving interpersonal conflicts about pregnancy and abortion, fear of reaction by parents and others, inexperience with the health care system and other factors are possible explanations. Teenagers, for whatever reasons, are probably being exposed to a greater risk than is necessary from a medical standpoint.

As for the short- and long-term social and psychological risks of abortion, studies in this area are incomplete but the findings are generally consistent. For the woman there are few apparent negative psychological consequences to legal abortion although there may be transitory effects.[23] Researchers have not looked at possible psychological consequences for the man responsible for the pregnancy that ends in an abortion for a teenager.

Findings on the consequences of abortion are difficult to evaluate in that they should be contrasted to other potential outcomes. Is an abortion "better" or "worse" than carrying a pregnancy to term and placing the infant for adoption? Are there more long-term negative effects of a "forced marriage" than of abortion? These are difficult comparisons to make and therefore an accurate assessment of the "costs" of abortion is not easy to come by.

However, the evidence does suggest that the teenage girl who thinks she might be pregnant should find out as quickly as possible. If she decides to have an abortion, the earlier she confirms the pregnancy and has the abortion, the safer the procedure. If she is planning to have the baby she should also begin prenatal care as soon as possible. Early prenatal care is important for the health of the baby and the mother, and adolescents are the least likely to seek such care early in their pregnancy.[24] Regardless of the anticipated outcome of the pregnancy, research shows that the earlier a course of action is entered upon, the more favorable the outcome.

Research is being reported from England which gives pause to the ease with which abortions may be undertaken for very young girls. Case data from J. K. Russell, Professor of Obstetrics and Gynecology at the University of Newcastle-upon-Tyne, on women who experienced abortions under the age of 16 reveal a disturbing picture of obstetrical and gynecological complications later in life.[25] The risk of trauma to the cervix, which tends to be small and tight in the younger teenager, appears far greater than for women under-

going first abortions over the age of 20. The reports from Dr. Russell are not so much an indictment of abortion, but rather a caution about the performing of abortions on very young women. Since upwards of 15,000 girls under the age of 15 had abortions during 1974 in the United States, this is not an insignificant problem. The available case data should be supplemented by long-term follow-up of a large sample of young women to assess the risks of abortion to that age group. Also, if the hypothesis regarding trauma to the cervix is correct, very early childbirth could also cause disproportionately more medical problems in later life.

Abortion and contraception

It is sometimes argued that liberal abortion laws will encourage the use of abortion as a substitute for contraception. This has not been supported by several studies which have probed for such a relationship. One such study was a pioneering in-depth survey of fertility-related attitudes and practices among a scientifically selected sample of 4,611 women aged 15 to 19 (only 8 percent of whom were or had been married), conducted across the United States in 1971 under the direction of John Kantner and Melvin Zelnik of Johns Hopkins University. The investigators asked their young respondents to imagine that a young unmarried girl finds she is pregnant by a boy she likes but does not love. What should she do? Only one-fifth of the sexually experienced among the respondents chose "end the pregnancy" as their solution, but 63 percent of those who made that choice had used contraception at last intercourse as compared with 35 to 49 percent of their counterparts who chose other solutions to the pregnancy. The researchers concluded that teenagers "presumably favorable to abortion are also those more likely to be current users of contraception."[26] Interestingly, a study of teenagers who had come to a family planning clinic for the first time showed they had more accurate information about abortion than about other methods of fertility control.[27]

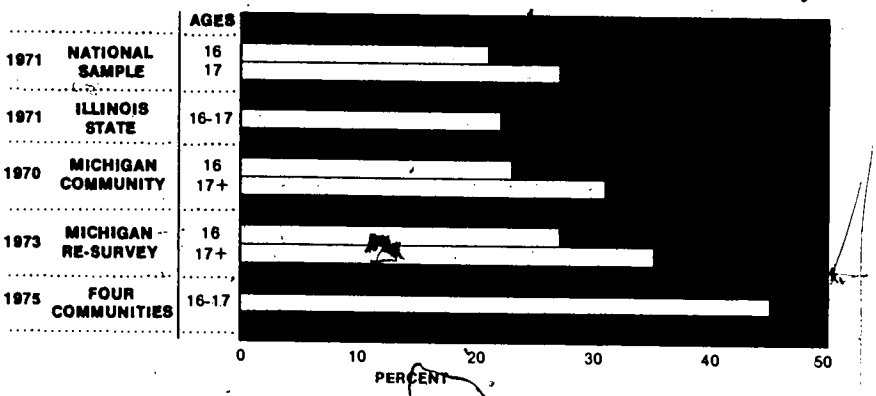
Sexual Activity

The Johns Hopkins study found that 28 percent of their unmarried teenage respondents had had sexual intercourse at least once, with the proportion increasing from 14 percent of those aged 15 at the time of the survey (1971), to 46 percent of those aged 19.[28] Different studies of this topic report slightly different proportions, but there is considerable similarity as seen in Fig. 5.

These data also support the popular notion that sexual activity among unmarried teenagers is becoming more widespread. In addition, there is some indication that sexual activity is beginning at earlier ages. In the Johns Hopkins survey of 1971, of the girls who were 19, only 3 percent reported having been sexually active before age 15, but of the girls then aged 15, 9 percent had had sex before age 15.[29] A study based on junior and senior high school students in Michigan found that in 1970, 16 percent of the girls were sexually active. In a comparable survey in 1973 the figure had risen to 22 percent.[30]

The United States has a long history of a double standard regarding sexual activity, but the tradition may be crumbling. Many studies report similar percentages of sexually active teenaged males and females, although a four-community study carried out in 1975 under the auspices of the American Public Health Association still found considerable differences among 16- and 17-year-olds. Sexual experience was reported by 67 percent of the males, and only 45 percent of the females. These are also the highest rates recorded in any of the studies reviewed.[31]

Figure 5. Percent of Unmarried Teenage Women Who Have Had Sexual Relations: Various Recent U.S. Surveys



Sources. National survey: Melvin Zelnik and John F. Kantner, "Sexuality, Contraception and Pregnancy Among Young Unwed Females in the United States," in *Research Reports*, Vol. 1, Commission on Population Growth and the American Future (U.S. Government Printing Office, 1972) Table 1. Illinois: Patricia Y. Miller and William Simon, "Adolescent Sexual Behavior: Context and Change," *Social Problems*, Vol. 22, No. 1 (October 1974) p. 62. Michigan: Arthur M. Vener and Cyrus S. Stewart, "Adolescent Sexual Behavior in Middle America Revisited: 1970-1973," *Journal of Marriage and the Family*, Vol. 36, No. 4 (November 1974) Table 5, p. 732. Four communities: Sarah S. Brown, E. James Lieberman, and Warren B. Miller, "Young Adults as Partners and Planners," presented at the Scientific Session of the 103rd Annual Meeting, American Public Health Association, Chicago, November 1975, p. 5

The phrase "sexually active" should be used with caution in regard to teenagers. Most studies conclude that the monthly frequency of intercourse is fairly low. Kantner and Zelnik report that 38 percent of their sexually active female respondents had not had intercourse in the previous month and the American Public Health Association study found that 15 percent of the sexually active students (both males and females) had not had intercourse in the preceding three months. Kantner and Zelnik also report 30 percent as saying they had intercourse only once in the preceding month and only 14 percent having intercourse six or more times.

Another way to look at premarital sexual activity is by the number of partners involved. To judge from these surveys, most teenagers confine sexual relations to one partner—very often the person they intend to marry. This was true of three-fifths of the sexually experienced women interviewed in the Johns Hopkins survey. As might be expected, however, the proportion declines with increasing age. Seventy percent of the white 15-year-olds had had only one partner compared to 50 percent of the 19-year-olds. The Michigan study of 1970 recorded only one partner for 64 percent of the sexually experienced girls and 42 percent of the boys, although there was a slight trend toward more partners in the companion survey of 1973.

Racial comparisons

Sexual behavior is another area where racial differences are very evident. According to the Johns Hopkins survey data presented in Table 8 (p. 16), black unmarried teenage women are far more likely than their white counterparts to *ever* have had sexual intercourse, especially at younger ages. Among the 15-year-old respondents, nearly three

times more blacks (32 percent) reported having had sexual relations at least once than did whites (11 percent). The racial difference narrowed considerably between the high levels of sexual activity reported by 19-year-olds—81 percent for blacks versus 40 percent for whites. These differentials could not be explained by social class differences between the two racial groups.

The survey data also suggested, however, that for many black girls sexual experience is less frequent and less indiscriminate than it is for those white teenage girls who do engage in such activity. Among the sexually active in both groups, more whites (16 percent) reported having had four or more partners than did blacks (11 percent), though equal proportions (60 percent) had had only one partner. Blacks were also slightly less likely to have had intercourse during the month preceding the survey.[32]

Evidence from the 1975 American Public Health Association study suggests that among sexually experienced teenage males first intercourse also occurs at considerably earlier ages for blacks than it does for whites.

Table 8. Percent of Sexually Experienced Unmarried Teenage Women, by Age and Race: 1971

Age	Black	White	Total
15	32	11	14
16	46	18	21
17	57	22	27
18	60	34	37
19	81	40	46
Total	54	23	28

Source: Melvin Zelnik and John F. Kantner, "Sexuality, Contraception, and Pregnancy Among Young Unwed Females in the United States," in *Research Reports*, Vol. 1, Commission on Population Growth and the American Future (U.S. Government Printing Office, 1972) Table 1, p. 360.

Patterns in Conceptions

We have seen that the birth rate for U.S. teenagers has declined, but since there are a large number of girls getting abortions it is not clear whether teenage girls are getting pregnant at a faster or slower rate than in the past. A rough estimate of the conception rate for teenage girls may be made by relating the annual total number of births plus abortions in this age group to the total number of women in the same age bracket, as follows:

$$\frac{\text{births + abortions to girls 15-19 in year X}}{\text{total population of girls 15-19 in year X}} \times 1{,}000$$

We shall assume that the rates of spontaneous abortion and stillbirths remain the same and can thus be ignored in estimating changes over time. Abortion data for the years before the Supreme Court decision on abortion are lacking but we can make some assumptions. First, we may assume that there were *no* abortions in 1960 to balance against the estimated 283,000 obtained by women aged 15-19 in 1974. Although this assumption is clearly untenable, it is used because it is least likely to show a decline in the conception rate. Nevertheless, under this assumption the rate of pregnancy for girls 15-19 would have declined by 4 percent between 1960 and 1974. This provides assurance that rates of pregnancy have declined in this age bracket, but by how much?

At the other extreme, we may assume that the abortion ratio is the same in 1960 and 1974. This would probably yield an overestimate of abortions in 1960 when the procedure was virtually illegal and therefore difficult to obtain. Under this assumption, the rate at which girls aged 15-19 became pregnant would have declined by about 36 percent from 1960 to 1974. We can surmise, then,

that the actual drop in the pregnancy rate is probably between 4 and 36 percent. Since it appears that more teenagers are sexually active, these figures may underestimate the decrease in the incidence of pregnancy among those who are sexually active. To put it another way, these figures suggest that there has been an improvement in the effectiveness of contraceptive practices among 15- to 19-year-olds.

Applying these same calculations to data for very young girls aged 10 to 14 yields a dramatically different picture. While the actual difference is unknown, it is likely that conception rates have increased between 47 and 250 percent in this age group over the same period.[33] Young teens have apparently increased their sexual activity without a concomitant improvement in contraceptive practice. Let us now look at the contraceptive behavior of adolescents.

Patterns of Contraceptive Practice

The extent to which sexual activity leads to pregnancy and the need for decisions about abortion or adoption is, of course, dependent upon the use of contraceptives. Adolescents do not appear to have consistent patterns of contraceptive practice, nor do they rely on the most dependable methods. To complicate the picture, the suitability of some popular methods for teenagers is also open to question.

The 1975 American Public Health Association study noted above reported that among their sexually active respondents about half of the females and 70 percent of the males had risked pregnancy at least once. The Johns Hopkins study found that 53 percent of the sexually active girls had not used a contraceptive method for their latest act of intercourse and 16 percent had never used a method. Only 27 percent of these girls reported always using some form of contraceptive protection. This figure includes those who knew when their fertile period occurred during the menstrual cycle and who avoided intercourse during that time.[34]

The sporadic nature of contraception changes somewhat with age. Among the sexually active Johns Hopkins respondents, only 29 percent of the 15-year-olds used a method the last time they had sexual relations, but 59 percent of the 19-year-olds were protected. Contraceptive diligence seems to improve with age and with increased frequency of intercourse. It is not clear whether women feel more at risk because they have intercourse more often and therefore use contraceptives more regularly, or whether some characteristic of the relationship, such as stability and communication, goes hand-in-hand with frequent sexual relations and helps remove some barriers to effective contraception.

The methods used by teenagers vary in the protection they provide against pregnancy. Among the sexually experienced never-married women of the Johns Hopkins survey, the most recently used methods were the condom (27 percent); withdrawal (24 percent); and the pill (21 percent). Blacks were more likely to use the condom and less likely to resort to withdrawal than whites.

Reasons for not contracepting

Many of these young women did not use a method because they did not feel they were at risk of pregnancy. An analysis of the reasons given casts some doubt on their understanding of the relationship between sex and reproduction. The most common explanation for not contracepting was that it was the time of the month when they couldn't get pregnant. However, [illegible] two-thirds (67 percent) of the whites and less than a quarter (23 percent) of the blacks correctly identified the middle of the men-

strual cycle as the fertile time and hence "unsafe" period.[35] This proportion is similar to that found in another study of contraceptive knowledge among teenagers.[36]

Even these figures may grossly overstate the level of knowledge concerning the rhythm method. First, the "middle of the month" is a vague definition of the period of greatest risk. Even a woman with a regular cycle will not locate the time of greatest risk with any accuracy unless she knows that the menstrual period begins with the first day of menstruation, not the last. Teenagers, many of whom do not yet have a fully regular menstrual cycle, are at an additional disadvantage in calculating safe and unsafe periods. Secondly, the study of new mothers in New York City mentioned above revealed that 45 percent correctly stated the period of greatest risk as being the middle of the menstrual cycle, but upon reinterview a year later nearly a third of these gave an incorrect answer.[37] Apparently, many women were guessing in the first place. We do not really know what proportion of the young female population correctly understands how to pinpoint the safe and unsafe periods of their menstrual cycles, but the evidence suggests that knowledge is shaky and has probably been exaggerated in research findings.

Some women who do not use contraception believe they are too young to become pregnant. In fact, many young girls do not begin to ovulate at the same time their menstrual periods begin. Since pregnancy cannot occur in the absence of ovulation, scientists believe that many young girls experience a time when, although menstruating, they cannot become pregnant.[38] However, no individual young woman is likely to know if she is ovulating or not and since there is considerable variability in post-menarche sterility, counting on it is very unreliable protection against pregnancy. Girls have even been known to become pregnant before having a period. The age of menarche appears to have declined in the United States over the past century, but the decline has been very slow. As noted, black girls are more likely to begin menstruating at early ages than are white girls, although three-quarters of both groups are menstruating by age 13 and over 90 percent by age 14. It is unclear whether our high nutritional standards have also shortened the period of post-menarche sterility.

Another reason given for not using contraception is that sex was infrequent, so contraception was not necessary. Frequency of intercourse bears some relationship to the risk of becoming pregnant, but since that risk is not equal throughout the menstrual cycle even low frequency can be associated with risk of pregnancy if it is poorly timed.[39]

Some adolescents object to contraception on the grounds that it takes the spontaneity out of sexual relations. This may reflect some difficulty in integrating contraceptive planning with a sporadic and unpredictable sex life. In fact, two of the methods most often used by teens —condom and withdrawal—are those most likely to be disruptive of the sex act. These methods are available with a minimum of hassle for the teenager and neither requires that a girl seem "prepared."

While over half of the teenage girls who are contraceptively protected rely on non-medical methods, a sizeable proportion take the pill and many obtain it through family planning clinics. How available are effective contraceptives for teenagers?

Teenagers and Clinical Services

By drawing data from a number of sources, Frederick Jaffe and Joy Dryfoos of the Alan Guttmacher Institute have estimated that as of 1975 more teenagers received family planning serv-

ices from clinics than from private physicians and that only half of the some 4 million women aged 15-19 estimated to be at risk of unintended pregnancy received medical contraceptive services in that year.[a] They note that it is unprecedented in the United States that more women receive care through a clinic than through a private physician..

In attempting to characterize these teenage patients the researchers observe: "Adult clinic patients are almost entirely low and marginal income women, but the socioeconomic classification of adolescent patients is more uncertain. It seems likely that family planning clinics serve a relatively larger proportion of adolescents than older women from higher income families, but many or perhaps most adolescent clinic patients probably are from low or marginal income strata."[40]

Jaffe and Dryfoos further report that between July 1, 1975, and June 30, 1976, 30 percent of the 3.8 million patients at organized family planning clinics were teenagers. Almost 10 percent of these 1.1 million teenage patients were 15 or younger. Nearly half had never used contraceptives before enrollment although it is estimated that upwards of 10 percent had had an abortion before attending a family planning clinic. Most teenagers who come to a family planning clinic want and obtain the pill although other methods are available. What are the advantages and disadvantages of the different methods for teenagers?

[a]This 4 million represents four out of ten women in the 15- to 19-year-old age group in 1975 and includes 700,000 currently married and 3.3 million never or previously married women. Presented in a report to the Conference on Determinants of Adolescent Pregnancy and Childbearing, sponsored by the Center for Population Research, National Institutes of Health, in Belmont, Md., May 3-5, 1976, the estimate is based on projected increases in the proportion of sexually active, unmarried women aged 15 to 19 since the Johns Hopkins survey of 1971—all of whom are assumed to want to avoid having children while still unmarried—plus estimates of the proportion of currently married women aged 15 to 19 not pregnant or trying to get pregnant derived from the June 1974 Current Population Survey of the Bureau of the Census. The procedure is described in Joy G. Dryfoos, "Women Who Need and Receive Family Planning Services: Estimates at Mid-Decade," *Family Planning Perspectives*, Vol. 7, No. 4 (July/August 1975) pp. 172-179.

Choosing Among Contraceptive Methods

The Pill. Oral contraceptives are the single most popular reversible contraceptive method among U.S. women today. Combining high efficacy with use independent of the sex act, the advantages of the pill are clear. There are also, however, significant disadvantages. There are medical indications against its use by women with vascular or clotting problems, diabetes, liver disorders, cancer and other conditions.[41] Actual pill taking involves medical risks, the most serious known adverse reactions being blood clots, high blood pressure and gall bladder disease. These risks, while increased for pill takers, are still small in absolute terms. More minor problems are weight gain, headaches, and an increase in minor vaginal infections. On the plus side, pill use serves to regularize and shorten menstrual periods and may improve acne conditions by its influence on the hormonal system. Physicians are not in total agreement about the advisability of prescribing a hormonal contraceptive to a girl whose menstrual cycle is not yet regular or whose body is still developing. On the other hand, the list of risks must be weighed against the risk of an unintended pregnancy and possibly abortion.

The pill's major advantage is its high degree of effectiveness in preventing pregnancy, but this is dependent upon its careful taking. A method appropriate for women with established sex lives

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and regular daily habits may not be suited to teenagers whose daily routines and sexual activities are apt to be unpredictable. Also, the pill requires a prescription which means the adolescent must contact a private doctor or clinic. Although many girls make this contact, it undoubtedly takes more motivation than reliance on a drugstore method.

IUD. Another highly effective method, the IUD, may be even less suited to adolescent needs. As with the pill, the IUD requires contact with a physician and is associated with major and minor effects. Relatively minor side effects are pain on insertion, painful menstrual periods and heavy menstrual flow. Major complications range from ectopic or tubal pregnancy while the device is in place, perforation of the uterus on insertion and pelvic inflammatory disease, to pregnancy following spontaneous and unobserved expulsion of the device. The only absolute contraindications against insertion are pregnancy or active pelvic infection.

Most IUDs are not suitable for women who have never borne a child and therefore it is not the method of choice for most adolescents. This disadvantage may be overcome by the newer Copper T and Copper 7. Both offer easier insertion and are better tolerated by women who have never had a baby. As with the pill, the long-term consequences of adopting this type of contraceptive regime early in a woman's reproductive career are not fully known. The IUD is effective in preventing pregnancy. its effect is reversible and independent of the sex act itself, and it requires little continuing attention by the wearer (except for checking that it is still in place).[42]

Diaphragm. The diaphragm, used with contraceptive jelly or cream, is a reasonably effective method of contraception but is not without its shortcomings. It requires a fitting by a professional and then must be put in place before each act of intercourse. For teenagers with unpredictable sex lives this can be quite problematic. Furthermore, the "equipment" involved—the device itself, jelly, applicator for additional jelly and possibly an inserter—must be kept by the woman. If a teenager is hiding her sexual and contraceptive activity from her parents this could be a disadvantage.

A major advantage to the diaphragm and jelly is that there are no negative side effects. Many women find they adapt to the routine of inserting the diaphragm and can use it with confidence and freedom from fear of side effects.[43] A recent study in a New York clinic demonstrated extremely high effectiveness even among teenagers when they were properly informed about how to use the diaphragm and motivated to avoid pregnancy.[44]

Condom. Often criticized for being unaesthetic or unreliable, the condom has many features to recommend it, especially for teenagers. Used correctly this method is quite effective in preventing pregnancy especially when used along with foam. It requires no physician contact, is widely available and has no negative side effects.[45] It does require preparation before each sexual act but not so much as the diaphragm.

Unfortunately, teenagers seem to have many erroneous ideas about the condom. In one study of teenagers' knowledge about sex and contraceptives, 48 percent believed that condoms break easily, although this is not true. After an instruction period the teenagers were retested and this question was still incorrectly answered by many.[46] Many teenagers accord the condom a low rating for reasons that are not clear. Perhaps some notions—even distorted ones—are so deeply entrenched in teen culture that they are difficult to change, or perhaps teenagers' beliefs are based on bad experiences with the condom as a result of inadequate information on how it should be used.

Since condoms are readily available—

albeit sometimes requiring a "Summer of '42" style episode to obtain—and offer good protection when used correctly, they are well suited to teenagers' sex lives. The condom also offers protection against venereal disease which is a serious health problem for teenagers as we shall see further on.

Withdrawal. Withdrawal is often used by teenagers and cannot be ignored as a contraceptive method. It was probably chiefly responsible for the historical decline in European fertility in the 1800s and early 1900s.[47] Nonetheless, there are several drawbacks to the method. Foremost of these is its unreliability which may be exacerbated by the teenage male's lesser control over his sexual response. On the plus side is its ready availability, with no "supplies" to obtain or hide. Also it is free, which may be an important factor for teens. There are no medical side effects of withdrawal but it may produce anxiety in both partners.[48]

Foam. Foam, and jellies and creams used without a diaphragm, are used by about 4 percent of married women and an unknown, but probably small, proportion of teens.[49] These techniques are simpler than the diaphragm and jelly but not as effective. The absence of side effects (except for an occasional sensitivity to a specific brand) may make them attractive and new pre-filled applicators lessen the interruption of sexual activity. Since these methods can be obtained without prescription they may be preferred by a young girl who does not want—or does not know how—to cope with clinics or physicians who deliver family planning services.

Douche. The age-old technique of douching to prevent pregnancy is not widely used except by black teenagers.[50] While not requiring a physician's intervention or inducing negative side effects, there is little to recommend the douche. To be used properly it involves equipment and must be used immediately after intercourse. The most compelling problem associated with this method is its very high failure rate.[51]

Rhythm. Rhythm—or periodic abstinence—may be based on calendar calculations of the time of ovulation or the more complex but reliable basal body temperature technique. Once the time of ovulation has been established, sexual relations must be avoided for a period of time before and after the estimated date of ovulation. Difficulty in pinpointing the time of ovulation and variability in the lifespan of the egg and sperm introduce a note of uncertainty to this method. Rhythm is a particularly difficult method to use correctly if a woman's menstrual periods are of irregular length. There are no negative medical side effects of the method but the effectiveness is low.[52]

Few teenagers say specifically that they are using the rhythm method, but 40 percent of sexually active Johns Hopkins respondents *not* using a method said this was because it was the "time of the month" they would not get pregnant.[53] We have already seen that teenagers' ability to even crudely estimate this "time of the month" is poor. Rhythm is a fairly complex method to use. Few teenage women apparently believe they are using it as their contraceptive method although some do use their perception of the anovulatory phase of the cycle as a reason for not contracepting.

The choice of a contraceptive method is not easy for anyone since each regimen has positive and negative features. The choice is undoubtedly more difficult for teenagers who may confront problems such as fear of appearing "prepared" for sexual relations, wanting to hide the method from parents, poor knowledge about the relative risks of different methods, or inability to negotiate the health care system to get help from a private physician or clinic. When we consider that upwards of 4 million U.S. teenage girls are estimated to be at risk of unintended pregnancy the magnitude of the problem is clear.

What of the Males?

There has been a lack of attention to the males involved in adolescent pregnancies. Since it is the female who arrives at a family planning clinic, has the abortion, or bears the child, she is more likely to have come into contact with a record-keeping system that translates her behavior into statistics. Because the woman faces more of the consequences of sexual behavior and has at least as great a chance to prevent them as does the male, research has also focused on her. Though understandable, this state of affairs is unfortunate. We know far less about how the male views the risk of pregnancy although he has an opportunity to avert it with contraception. To judge from the Johns Hopkins survey, over half of contracepting teenagers are using male methods—condom and withdrawal—so clearly males have not given up all responsibilities.

While many males do use contraceptives, many others do not. We have seen that some female teenagers fail to use a method because they think they cannot get pregnant and there is evidence that males share those views. Fewer than half the young males surveyed in an urban area could correctly identify the period in a woman's menstrual cycle when she is at greatest risk of pregnancy. Half of the boys questioned also said they felt the girl should be the one to use contraception.[54] When this is combined with the data on girls the picture is dismal. Both sexes feel that contraception makes sex seem calculated and report that it was not used because of a desire not to deprive the sex act of the spontaneity it is supposed to have. Both males and females appear equally uninformed about the physiology of reproduction and the effectiveness of various contraceptive methods—even those methods which teenagers do use.

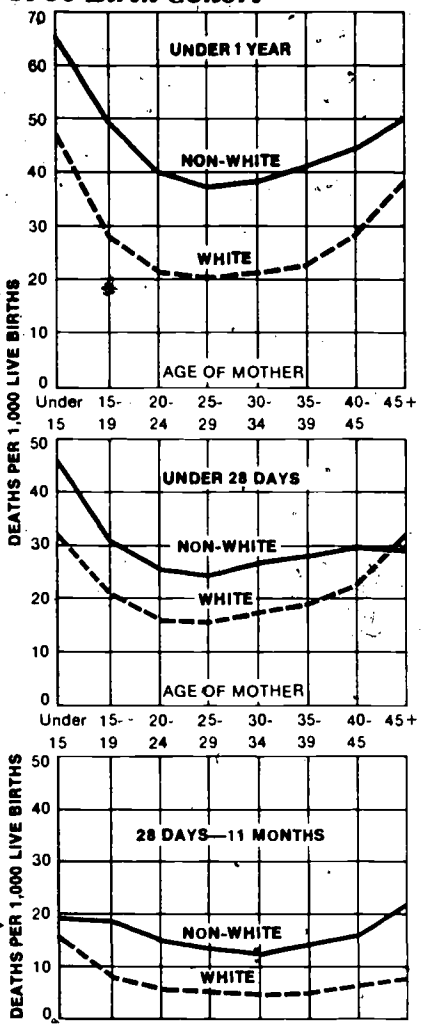
Health Consequences of Adolescent Childbearing

One area of significant risk associated with childbearing during the teenage years is health—health of the mother and health of the baby. The risks involved start with the pregnancy itself. Serious complications of pregnancy such as toxemia (a condition which causes hypertension), pre-eclampsia, and prolonged labor are all more common among teenagers than older women. While some of these difficulties may result from poor diet or prenatal care, others are related to the physical immaturity of the woman. The risk of fetal loss is not particularly high for a teenager bearing a first child, but is much greater if she is having a second or higher order birth.[55]

Both the adolescent who gives birth and her baby are at greater risk of death than is the case with a woman in her twenties. The maternal mortality rate is highest for girls under the age of 15 and still quite high for girls aged 15 to 19. The only other age group that approaches these rates comprises women 40 to 49. The risks of late childbearing are generally known, but the risks from very early childbearing are also serious.[56]

Jane Menken draws attention to data on the 1960 U.S. birth cohort which reveal that among both whites and nonwhites a similar pattern exists for mortality risks to the baby (Fig. 6). The differences in risks are far greater in the first month of life than in the remainder of the first year. Menken remarks: "Just after birth, when biologic factors related to the pregnancy are the primary determinants of survival, risks to infants of younger mothers are much higher than those to infants of older mothers in both

Figure 6. Infant Mortality Rates by Age of Mother and Race: United States, 1960 Birth Cohort



Source: Committee on Maternal Nutrition, Food and Nutrition Board, National Research Council, *Maternal Nutrition and the Course of Pregnancy* (Washington, D.C. National Academy of Sciences, 1970) p. 144.

color groups."[57] If a teenager is having her second or third baby the mortality risks for the baby are even higher.

One problem associated with assessing the health risks of adolescent childbearing is that data are often presented in five-year age groups, such as 15-19. This obscures the differences between young teenagers and older teens. The health risks for a woman aged 18 or 19 are not much different from the risks for a woman in her early twenties, but the risks for the 15- or 16-year-old are considerably greater. Within the 15-19 age group the risks from pregnancy and childbirth are greater the younger the mother. Also, the risks generally increase with parity so that, while an 18-year-old may not be at any appreciable risk if bearing a first child, the 18-year-old who is pregnant with a second child may experience considerably increased health risks.[58]

Low birth weight

One explanation for the higher mortality rates among babies born to teenagers is the greater incidence of low-birth-weight infants. Teenagers are more likely than older women to give birth to a baby weighing 2,500 grams or less and the risk of death for such an infant is considerably higher than for a baby born weighing more than 2,500 grams (about 5½ pounds). Table 9 (p. 24) shows the probabilities of a low-birth-weight newborn according to maternal age and racial group. Nonwhite mothers have a greater risk than whites of bearing a low-birth-weight baby at all ages, but the young girl, white or nonwhite, is at the greatest risk.

Besides increased mortality risks, low birth weight is related to a number of developmental problems for the infants involved, including cerebral palsy, epilepsy and mental retardation. Of course, not all low-birth-weight babies suffer these complications, but the risk is clearly increased.[59]

Table 9. Percent of Low-Birth-Weight Infants by Age of Mother and Race: United States, January-March 1967

Age of Mother	Total	White	Nonwhite
under 15	17.2	12.5	19.5
15-19	10.5	8.5	15.7
20-24	7.7	6.7	13.2
25-29	7.2	6.5	11.8
30-34	7.9	7.0	12.6
35-39	9.1	8.3	13.3
40-44	9.6	9.1	12.2
45 and over	8.6	8.1	10.8
Total	8.2	7.1	13.6

Source: Helen C. Chase, "Trends in Prematurity United States, 1950-1967," *American Journal of Public Health.* Vol. 60 (1970) Table 8, p. 1,978.

There is one small bright spot in the catalogue of health problems associated with early motherhood. Women who bear their first child before the age of 18 apparently have a decreased risk of breast cancer. For them, this risk is one-third that for women who wait until age 35 to begin a family.[60] Few women want to wait until age 35 to start their families—a time when other hazards increase—and this one advantage to a teenage first birth is minimal compared to the benefits associated with bearing a first child between the ages of 20 and 24.

Teenage Health and Sex

Pregnancy and childbearing are not the only health "risks" run by sexually active adolescents. Teenagers now feature prominently in the U.S. statistics on venereal disease. Although the rate for syphilis has declined dramatically in the past 30 years, the rate for gonorrhea has risen. Close to a million cases of gonorrhea were reported across the nation in 1975. When under-reporting and under-diagnosis of cases are considered, the Center for Disease Control estimates that there are upwards of 2.6 million cases annually, or about one new infection every 12 seconds. While men still account for about 60 percent of the reported cases, the rate for women is now mounting faster than that for men. Highest rates are found among 20- to 24-year-olds, closely followed by rates among 15-19 year-olds. The rate of infection by gonorrhea has about tripled since 1956 and now stands at 1,216 cases per 100,000 population for teenagers—three times the overall rate of 429 for the country.[61]

The complications of gonorrhea are serious and may result in sterility. One disturbing characteristic of the condition is that it is often without symptoms in women. Also, gonorrhea must be diagnosed through a smear rather than an easier to obtain blood test, although scientists are working on a blood testing technique.

As for syphilis it has not been eradicated, but relative ease of detection and cure, along with generally understood symptoms, makes this an easier disease to control. The risk of syphilis is highest for young adults (20-24) but teenagers, with 19.5 cases per 100,000, are still above the national rate of 12.1. Other medical problems that are sexually transmitted are infections in the genitals, such as nonspecific urethritis, trichomoniasis and genital herpes. All are believed to be on the increase. Since reporting of these to the Center for Disease Control (CDC) is not required, it is difficult to assess how widespread they are, but the CDC puts the annual total of trichomoniasis alone at 3 million cases.[62] Sweden has registered a decline in venereal disease, which may be due to high rates of condom use. Denmark, where living conditions and cul-

ture are quite similar, has had no such reduction in V.D., nor does it have high rates of condom use.

It is quite likely that health risks other than venereal disease accompany early sexual activity. I. D. Rotkin found age at first sexual intercourse to be the factor most closely associated with risk of cervical cancer for women. This relationship holds regardless of sexual frequency, number of partners, and whether or not a woman's partners had been circumcised. Adolescence appears to be the period of greatest susceptibility but the long latency of cervical cancer means the disease may not surface for several decades. The hypothesis proposed by Rodkin is that, in its high growth state when cells are dividing, the cervix of a female teenager is particularly vulnerable to viral agents which may be transmitted by a sexual partner. While the evidence for this hypothesis is not complete, it is consistent with other evidence regarding the development of cancer. Use of the diaphragm or condom are two methods of short-circuiting this sequence of events.[63]

Child Development

Some data are available on the effects of early parenthood on the later development of the child or children involved. In an extensive review of pregnancy outcome and child development as related to parental age at birth, Dorothy Nortman reported on a study which found childhood mortality at ages 1-4 to be 41 percent above average among children born to adolescent mothers, with a rapid decline as the age of the mother increased. She noted that accidents are an important cause of childhood deaths, and the implication is that teenagers may be too immature to act as responsible parents.

She further cited a Canadian study which showed an increased prevalence among adolescent mothers—especially for high parity women—of handicapped children. And a study of mental defectives found them over-represented among mothers under the age of 20 and among mothers over the age of 35.[64] As with many such problems, there is a J-shaped curve of risk. Risk is elevated for young mothers, lowest for women in their twenties and higher for older mothers.

Dr. Janet Hardy has reported data from the Johns Hopkins Child Development Study on the development of 525 children born to girls who were 16 years or less at the time of delivery. At age four, 11 percent of the children scored 70 or below on IQ tests compared to only 2.6 percent of the general population of four-year-olds. While in the general population approximately a quarter of four-year-olds will demonstrate an IQ of 110 and above, only 5 percent of the children born of very young mothers tested that high. Dr. Hardy noted that school failure and behavior problems are also more prevalent among the study population. "Other serious problems such as child abuse, delinquent behavior and early pregnancies among the children themselves have been encountered. Yet, some of the young mothers and their children have been successful. These mothers have completed their schooling, hold good jobs, have established satisfactory family life and their children are doing well and should be successful also."[65]

To say that there are greater risks for children born to adolescent mothers does not mean, of course, that all such births will lead to problems any more than to say that delaying a birth until the twenties will guarantee that child a splendid life. We can say that the risk of negative outcomes for the pregnancy, the birth, or for the child's development, are higher the younger the mother. Postponing a birth until a woman is in her twenties offers noticeably decreased risks in all respects.

Life Chances for a Teenage Mother

A birth during adolescence has an effect on many other aspects of a woman's life besides her health, and the effect is generally negative. What does becoming a mother as a teenager imply for a woman's education, her potential employment and earnings, and her future childbearing?

Education

Pregnancy and motherhood are major reasons for girls leaving school. Of course, some girls drop out of school and then become pregnant, but that is not the usual case. One analysis has shown that only 20 percent of the women who bore a child before the age of 18 completed high school. This study found very little difference between black and white women in this respect.[66]

Title IX of the Education Amendments of 1972 (effective July 12, 1975) prohibits schools which receive federal funds from excluding any student on the basis of pregnancy or a pregnancy-related condition. Even so, the extent to which young women stay in school during pregnancy or are able to return after a birth varies widely. The demands of child care may make it difficult for some new mothers to remain in school, even if they are not barred by school policy.

The New York study of new mothers found that of those who had not completed high school, 27 percent were in school after the birth, and over half (56 percent) wanted to go further in school. Interestingly, the proportion who were in school or wanted to go further was about the same for those who had not completed high school as for those who had. These young mothers are not without educational aspirations, but they are not completely successful in achieving them, either. It seems plausible that more of these young women would be in school had it not been for an early first birth.[67]

It is clear that pregnancy and birth have a negative effect on a woman's education but it is difficult to say how much of the deficit is made up later in life. The effect of a birth may also vary with the age of the mother. A girl who is only 15 when her baby is born may not be expected to assume full responsibility for the baby and therefore be able to continue in school while a relative, perhaps her mother, cares for the child. A girl of 17 is more likely to take on the full role of mother and perhaps wife and find that she does not have the time or energy to cope with school in addition.

Employment and earnings

Earnings are generally a function of formal schooling and on-the-job experience. The girl who bears a child while still an adolescent is likely to both interrupt her school and make it difficult to find work because of her child care responsibilities. It is difficult to assess the exact impact of a teenage birth on labor force participation, occupation and earnings, but it is clear that women who begin childbearing in their teens have disturbed the process by which one achieves success in the market place. A long-term study of family incomes among Detroit couples found persistently lower earnings and assets among couples who had married when the bride was already pregnant compared with those who had not. This reduced economic achievement was not the result of shorter duration of marriage, younger age at marriage, or social status of the parents.[68]

Fertility

Numerous studies report that the earlier a woman begins her family the more children she is likely to have. This ap-

parently results not from a desire for more children but from having more unplanned births. The New York study of new mothers found that only 20 percent of the teenagers had planned their births as compared to 70 percent of the women who were 24 to 29. The teenage mother is less likely to intentionally embark on motherhood for her first birth and the pattern may repeat itself with later pregnancies.

Bonham and Placek report data from the 1973 National Survey of Family Growth regarding family size expectations for women who had their first child at ages under 18, 18-19 and older. The younger the woman at the time of her first birth, the more children she eventually expected to have (Table 10).

Divorce

Among married teenage women, who have most of the births to teenagers, does childbirth affect the stability of marriage? Couples who marry before the woman has reached age 20 have much higher rates of divorce than those who marry later; but one analysis based on the 1970 National Fertility Survey does not show significantly increased risk of divorce because of an early birth.[69] There is an adjustment by a married couple to the arrival of a first baby and there is an increased economic burden. These adjustments must be more difficult for a young couple when the birth is likely to be unplanned, and there has been less time for the couple to adjust to married life and accumulate economic resources. However, the teenage birth does not in itself doom the teenage marriage. The explanation for this may simply be that early marriages suffer considerable strains regardless of whether or not there is an early birth. On the other hand, it is not accurate to conclude that teenage pregnancies have *no* association with divorce since such pregnancies undoubtedly often precipitate early marriage. The National Fertility Survey analysis did, however, show that women who already had an illegitimate child at the time of marriage had a higher risk of divorce regardless of their age at marriage.

Table 10. Total Births Expected per 1,000 Ever-Married Mothers by Age at First Birth: 1973

Age at first birth	Births expected per 1,000 ever-married mothers
Under 18 years	3,766
18-19 years	3,224
20-21	3,050
22-24	2,787
25-29	2,494
30+	2,144

Source Gordon S Bonham and Paul Placek, "The Impact of Social and Demographic, Maternal Health and Infant Health Factors on Expected Family Size. Preliminary Findings from the 1973 National Survey of Family Growth and the 1972 National Natality Survey," presented at the Population Association of America meeting, Seattle, Wash., April 1975

Suicide and child abuse

Other consequences of early childbearing may include the risk of abuse for the child or suicide for the mother. Both are plausible since the teenage mother is often raising a child under stressful circumstances. The child is often unwanted or at least unplanned, the mother may not have the support of the child's father or the social support available to older mothers. The woman by virtue of being less mature may be less prepared for the demands of motherhood. The data to support these hypotheses are not extensive, however. Gabrielson and colleagues have reported that the incidence of suicide is more frequent among teenage mothers than non-mothers, but it is not clear if both the

pregnancy and the suicide were related to a common problem which preceded either event.[70]

It is also the impression of people writing in this field that teenage parents are at increased risk of abusing their children but this is difficult to establish.[71] Statistics on child abuse are incomplete and it is questionable that the reporting is unbiased in regard to characteristics of the parent. More research is needed to understand the factors leading to child abuse as well as to assess the range of consequences—good and bad—of teenage childbearing.

Services for Teenage Mothers

It is beyond the scope of this *Bulletin* to catalogue the hundreds of programs in the United States designed to assist school-agers who become parents. These services are in addition to the network of clinics offering family planning and abortion. One may conclude that the availability of services for adolescents has expanded considerably in the past few years but that current programs are not adequate to meet the need. Programs vary widely in what they provide and where they can be found. Urban areas tend to provide a much better array of services than rural areas.

Some studies of programs for school-age parents illustrate a problem that may result when services are designed to achieve only short-term goals. One project contrasted the health of babies born to adolescent mothers who were part of a comprehensive program of pre- and post-natal care with that of children born to similar mothers who were not in such a program. As might be expected, the mothers in the special program had healthier babies. This demonstrated that intervention with nutritional supplements, health care and counseling had a beneficial effect. However, subsequent births to these same mothers which did not receive such attention showed poorer results. Prematurity, low birth weight, and perinatal mortality were all significantly higher among the 103 subsequent births than among the 180 index infants.[72]

Perhaps a more common problem with short-term goals of programs for young mothers is found with those designed to help pregnant teenagers stay in school. Such a program may be able to assist a girl through the difficulties of continuing in school during pregnancy, getting health care and planning for the baby, and then find that once she has had the baby her child care problems keep her from returning to school and graduating.

Women who first bear a child as an adolescent may encounter medical, developmental and social problems at that time and with that child, but the increased risks may apply to later-born children as well. An intervention program that ameliorates some of these problems is valuable, but the problems may be persistent. The later-born child may still be affected by the mother's or father's truncated education, diminished occupational skills, marital disruption or the mother's altered reproductive system.

Service programs have shown that it is possible to help avert some of the negative consequences of early pregnancy, but they have also revealed that many problems associated with adolescent childbearing are complex and may require a broad perspective if we are to be successful in ameliorating the consequences.

Consequences for Society

The costs of adolescent sexual and reproductive behavior for society are complex. Behavior which results in health problems generally results in costs not

only to the individual but also to the society which may subsidize the treatment. Information on the public support of medical care shows that, in 1967, hospital costs for 52 percent of out-of-wedlock births and 10 percent of legitimate births among white women were paid for out of public funds. The corresponding figures for blacks were 76 percent and 40 percent.[73] Of course, only about half of out-of-wedlock births are to teenagers, but we may assume that teenagers would be no less likely to need such support and may well be more likely to. According to the 1972 National Natality Survey, one third of the women under 18 having a legitimate birth in that year had their hospitalization paid in part or fully by an agency or organization. The percentage falls to 25 for women 18-19, and decreases steadily as age increases to less than 10 percent for mothers 35 and over. This payment may have been from public sources or the military. Conversely, the proportion of women having hospital bills paid by private insurance rises steadily with the age of the mother.[74] These data are not surprising—they only confirm what logic would imply—that the young mother, married or not, is less likely to be economically established and able to pay for her health care.

For the adolescent mother who bears a child the costs, of course, do not end with delivery. To cite again the New York City study of new mothers, it was found that more than half (55 percent) of the teenage respondents were in households receiving public assistance as opposed to 17 percent of the mothers aged 20-23 and 9 percent of those aged 24-29. Public assistance may be the means by which young mothers are able to return to school, for this same study showed that of the teenage mothers enrolled in school, three-fourths were in households receiving public assistance. Since these are the girls least likely to be able to find a job, such assistance may be the most constructive reaction to an untimely first birth. The women who received public assistance after the first birth were *less* likely than other women to have another baby in the follow-up period of the study. While these data do show that many young girls are in households receiving public assistance after the birth there is no evidence that such assistance results in more rapid second births.

The cost accounting for adolescent pregnancy and childbearing is quite complex, and incomplete. It is difficult to assess all of the costs, direct and indirect, that the individual and society may bear. It is also difficult to assess the cost of all alternative courses of action. However, it is generally agreed that family planning services are "cost-effective" in that they are less expensive than the consequences of pregnancy and childbirth. This cost-effectiveness undoubtedly carries over into the non-economic sphere since the emotional costs are far less for contraception than for bearing an unwanted child, or an unplanned child that leads to a precipitate marriage, reduced educational and occupational opportunities, or other consequences.

International Comparisons

How does the United States compare with other countries in regard to teenage reproductive behavior? Many developing countries exceed this nation in the proportion of adolescent women who are married, or the extent to which childbearing takes place during the teenage years. However, the level of teenage reproductive activity in the United States exceeds that of other developed, or industrialized countries. In highly industrialized Japan, for example, teenagers account for only 1 percent of births in contrast to nearly 20 percent

Table 11. International Comparisons of Childbearing and Marriage Among Teenage Women

Country	Birth rate of women under 20[a]	% all births to women under 20[a]	% illeg. births to women under 20[b]	% marriages to women under 20[a]
United States	68	19	25	33
England and Wales	50	11	21	26
Sweden	33	7	60	7
Japan	5	1	5	3
France	26	7	17	20
Chile	70	15	30	31

Sources: United Nations, *Demographic Yearbook 1969* (Table 25), *1972* (Tables 6 and 17), *1974* (Tables 10 and 12)
[a]1971-1973. [b]1967-1968.

in the United States. England, which is culturally quite similar to the U.S., reports only 11 percent of births occurring to teens, and the figure for Sweden is 7 percent (Table 11). Of course, the proportion of births attributable to teenagers is influenced by birth rate trends among older women as well as teenagers themselves. As we have seen, the greater downturn in the former have had much to do with the increase in the teenage proportion of all U.S. births in recent years.

Data for international comparison are available for approximately the same time periods from the United Nations *Demographic Yearbooks*. Table 11 gives several measures of teenage reproductive behavior for the United States and five other countries. There are large differences which reflect social and cultural variations in the propensity for adolescents to marry, bear children and have children out of wedlock. It is not surprising that the studies that are available infer similar rates of sexual activity among adolescents in the United States and Britain or that rates for Japanese teenagers are much lower.[75]

The pressures that exist to refrain from or engage in sexual relations and the extent to which intercourse leads to pregnancy and birth vary from country to country. Sanctions against abortion or against bearing a child out of wedlock also vary and influence the availability of birth control and abortion services as well as the extent to which pregnant adolescents marry.

The Outlook

To sum up, there is justifiable concern about adolescent childbearing because of the negative outcomes so often experienced by the mother, child, and others involved. It is difficult to find anything that is not better when birth is postponed. In one sense the "problem" of adolescent childbearing is diminishing in the United States, for we can see substantial declines in the birth rate for most teenagers. However, the declining rate for older teenagers is coupled with rising rates for younger teens and the rates for nonwhite girls remain substantially higher at all ages than for whites. The very large numbers of U.S. teenagers today means that, even with declining rates, there are large numbers of

births to teenagers. Thus, the magnitude of the problem has not diminished greatly, if at all.

Adolescent childbearing is clearly a risk for the young teenager. A girl who is 18 or 19 does not face particular biological risks from a pregnancy, but a younger girl does. The social consequences—for the parents and children—of too early childbearing are also negative. While the general picture is clear, the details about magnitude and reversibility of effects remain for future research to clarify. Such research will hopefully turn from the myopic view of adolescent childbearing and look at people other than the mother. The effects on the father, on the extended family which may be called upon to help raise the child, and on society should receive more attention than they have to date.

Childbearing is only one aspect of the whole issue of teenage fertility-related behavior reviewed here. Rates of sexual activity are apparently increasing for adolescent women. Even so, sexual activity is not typical of teenagers, except for older, and especially black teenagers. Given the sporadic nature of sexual activity among adolescents it is difficult to say just what "sexually active" means.

Most of the teenagers who are sexually active make at least some attempt to avoid pregnancy. This does not, however, mean consistent use of the most effective contraceptives. The general unpredictability of their sexual activity, misconceptions about the risk of pregnancy, personal and intra-couple barriers to contraceptive use, and barriers to contraceptive services all combine to make contraception for adolescents a difficult experience. Moreover, in seeking protection from unwanted pregnancies adolescents find—as do adults—that there is no perfect contraceptive. Methods differ in their intrinsic ability to prevent conception, but they also differ in what they require from the user in order to make the method successful. Methods that seem ideal for adults may be inappropriate for adolescents.

Despite attitude survey findings which indicate adult approval for the provision of family planning services to teenagers,[76] this service is not uniformly available for adolescents. Teenagers perceive problems in obtaining service and there is reason to believe that the use of contraception would increase with improvements in the delivery of family planning services. Since the effective use of contraceptives is related to understanding the risks of pregnancy and the characteristics of different methods, it seems imperative that improved services to teenagers include an educational component.

There is a great deal of information available about sex, reproduction, contraception, the effects of too early childbearing, services for teenagers, and so forth, but little of it appears to be in the hands of the adolescents involved.

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Adolescent Fertility Update

(For this May 1977 reprint, Wendy Baldwin has updated the picture of U.S. teenage fertility with material available since the first publication of the Bulletin *in September 1976.)*

Data for 1975 show continuation of a number of adolescent fertility trends already noted in this *Bulletin:* (1) overall, birth rates for teens declined from 1972-74 levels, with a rise only in birth rates for very young girls; (2) the number of births to teenagers decreased from 1974; (3) the number of out-of-wedlock births rose among teenagers; and (4) the illegitimacy rate for women 15-19 increased, but only among whites.

The birth rate for women 15-19 continued to decline in 1975, reaching 56.7 per 1,000—3.4 percent lower than in 1974, as seen in the table below. As in the past, the rate of decline varied by age and race. The one-year declines were smallest for the youngest girls and white girls aged 14 actually showed a slight increase (2.3 percent) to a rate of 4.4 births per 1,000. Nonwhites showed no such increase at any age. The declines in fertility rates were slightly greater for nonwhites although their rates are still substantially higher than those for white teenagers.

A look at the 1970-75 trends shows lowered fertility rates for all nonwhite adolescents and lowered rates for whites 16 and older. Breaking this into first and higher order births, we see that the only rates that are rising are first birth rates for white girls under age 16. First birth rates are down considerably for older white teens and higher order birth rates have fallen for all ages, although somewhat more modestly. Nonwhites show a somewhat different picture. While their fertility rates remain well above comparable white rates, they have registered declines at all ages and parities. Furthermore, the declines have been greatest for higher order births.

Declines in rates are not always accompanied by decreases in numbers but in 1975, the absolute number of births to women under the age of 20 also dropped. The total of 594,880 was 2.2 percent below the 607,978 total of 1974. This decline was completely accounted for by the fall in births to women aged 15-19 since numbers of births to women under 15 actually rose about 1 percent from 12,529 in 1974 to 12,642 in 1975. In 1975, births to women under 20 accounted for 18.9 percent of all births, about the same as in 1974. This proportion varies widely by race, with some 16 percent of white births and 30 percent of all nonwhite births being to women under 20.

Birth Rates for U.S. Teenagers, 1975

Age	Births per 1,000 women		
	Total	White	Nonwhite
14	7.1	4.4	22.1
15	19.4	13.4	51.2
16	36.4	28.1	82.3
17	57.3	46.9	114.5
18	77.5	66.3	138.9
19	92.7	82.2	151.0
15-19	56.7	47.4	107.6
% change 1974-75	-3.4	-3.5	-4.3

Source: Robert L. Heuser, Chief, Natality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics, personal communication.

Out-of-wedlock childbearing

The total number of out-of-wedlock births in the United States increased by 7 percent between 1974 and 1975, rising to an all-time high of 447,000. Of these, 233,500 were to women under the age of 20, up by 5.6 percent over 1974.

In 1975, 14.2 percent of births to women of all ages were out of wedlock.

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Among teenagers, however, 39 percent of all births were out of wedlock, up from 36 percent in 1974. This one-year increase was nearly as great as that registered from 1970 to 1974. The 1975 proportions of out-of-wedlock births were 23 percent for white teenagers, 78 percent for blacks, and 45 percent for adolescents classified as "other."

The 1975 illegitimacy rate of 24.8 births per 1,000 unmarried women aged 15-44 was up 2.9 percent over that of 1974. For 15- to 19-year-olds, the illegitimacy rate went up 4.3 percent to 24.2 births per 1,000 unmarried women. This is the highest such rate ever observed for this age group. From 1974 to 1975 the illegitimacy rate rose slightly (2.3 percent) for women aged 20-24 to 31.6. Because of this reversal of previous trends for this age group, the proportion of all out-of-wedlock births that were to teenagers dropped slightly from 52.9 percent to 52.1 percent. While white rates are lowest, they showed the only increase between 1974 and 1975.

What do these figures mean? Is the "problem" of teenage childbearing over because the birth rates are generally declining? I do not think so. If we are concerned about the women and children (and other family members) who may be affected by a birth to a teenager, the number of people involved has hardly changed from the 1960s when the rates of teenage childbearing were very high. In fact, an increasing number of these births are occurring to the youngest women, those least able to care for a baby and those at the greatest risk of medical complications. Also, the increasing number of teenage out-of-wedlock births may mean that more births are occurring in situations that are problematic to the mother, the baby, and society.

If declining birth rates do not mean the end of the "problem" of teenage childbearing, what do they mean? In 1976, Zelnik and Kantner of Johns Hopkins University again conducted a national survey of fertility-related practices among women aged 15-19.[1] Comparison of the findings with those of their 1971 survey indicate that premarital sexual activity among women of this age has continued to rise. In 1971, 27 percent of never-married women surveyed reported having had sexual intercourse at least once. By 1976 the figure was up to 35 percent, an increase of 30 percent in just five years.

Increasing sexual activity but declining birth rates among teenagers must mean that teenagers are becoming increasingly able to control their fertility either through contraceptive practices or abortion. The 1976 Johns Hopkins survey did indeed reveal a drop of about one-third over 1971 in the proportion of never-married 15- to 19-year-olds having unprotected intercourse. It also revealed that teenagers are using more effective methods of birth control. In 1976, almost one-third of the sexually active women surveyed used the pill, almost twice the proportion of 1971, and the increase was more dramatic for 15 to 17-year-olds than for the oldest teens.

Despite this encouraging increase in contraceptive practice, a recent review of family planning services for teenagers notes that teenagers are still underserved compared to the overall population of women in need of family planning services.[2] Also, although abortion services are increasingly available they are not uniformly accessible in all 50 states, and adolescents seeking abortion still have more problems than older women. Thus, the improvement in teenage fertility control is being achieved despite imperfect services. How much lower would the birth rate be for teenagers if services were improved?

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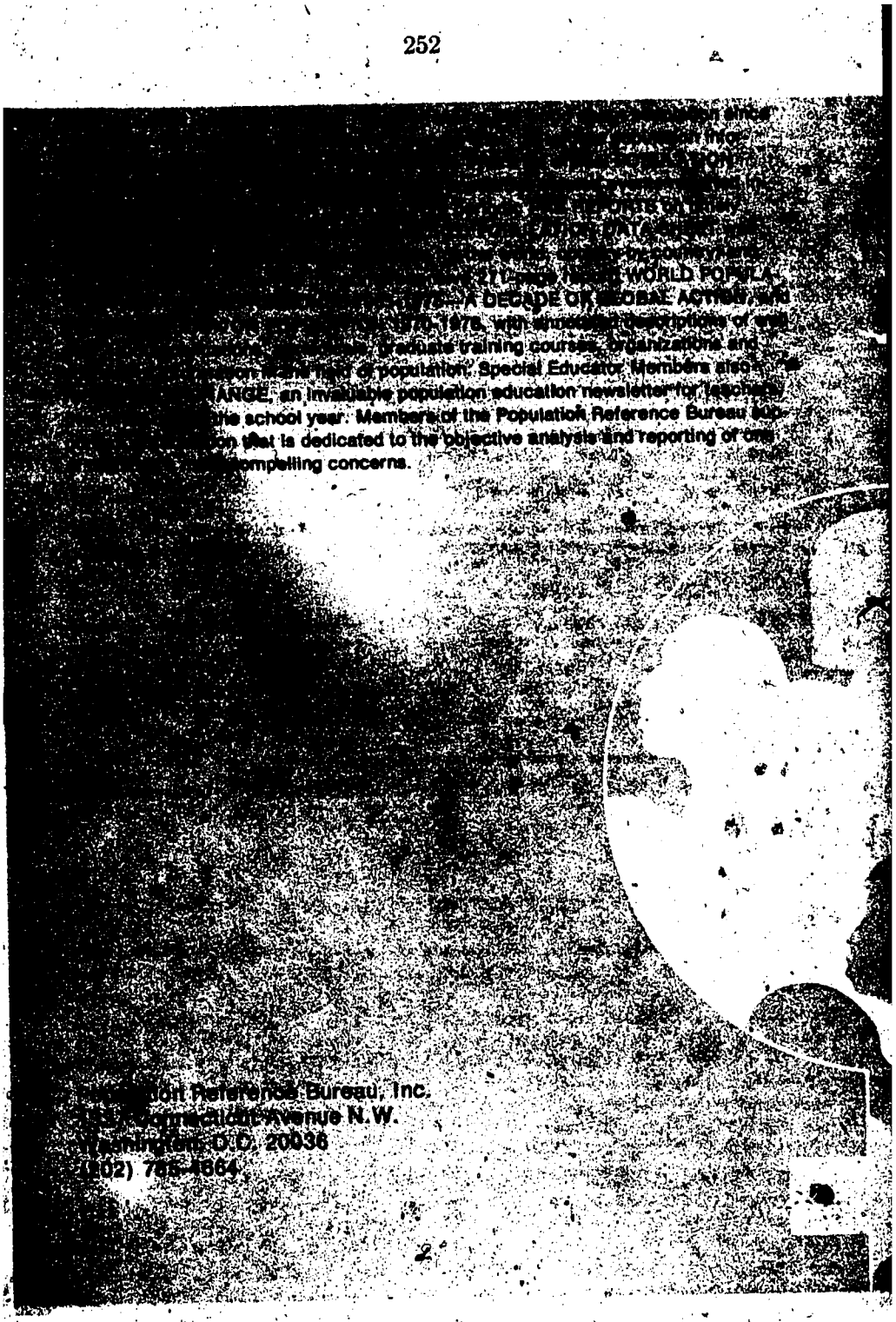
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Senator RIEGLE. That analysis is very helpful to us and certainly bears out the need for exactly the kinds of initiatives that this bill was designed to provide.

Dr. Moore or Ms. Forbush, who would like to go next?

Dr. MOORE. I believe my testimony follows Dr. Baldwin's most directly.

Senator RIEGLE. Do you want to identify yourself for the record?

Dr. MOORE. Yes. Dr. Kristin A. Moore, research associate, Urban Institute in Washington, D.C.

A significant proportion of all childbearing in the United States takes place during the teenage years and often outside of marriage. Over the past 2 years, our research program has been attempting to trace out the social and economic consequences of these trends. Our work indicates that teenage childbearing leads to important consequences for the young mother and her family. Related analyses suggest that childbearing is also costly to society in general since an early birth seems to increase the odds that a mother will require welfare assistance. The economic impact of an early birth is not direct. Rather, it seems to trigger a chain of events that combine to undermine economic well-being.

The most critical factor is the reduction in educational attainment that seems to result from a teenage birth. However, subsequent childbearing plays a crucial role, as well as marital instability and lower income on the part of other household earners.

Results of our analysis clearly indicate that early childbearing is associated with significant educational losses. For example, among the young women, age 24, in one study, girls who bore a child at 15 or younger, had completed only 9 years of school on the average. Those who had a first birth at 16 or 17 completed 10½ years on the average.

Early marriage also has a significant negative impact on the years of schooling a young woman is able to complete. It is difficult to sort out the effects of an early birth from early marriage since they so frequently occur together. However, it is clear that the young woman who both has a child and who marries is the most likely to drop out of school. The young woman who bears a child but does not marry is only half as likely to drop out as the young woman who becomes both a mother and wife. Whether she marries or not, though, the school-age mother is considerably more likely to discontinue her formal education than a teenager who has not borne a child.

We also looked at the issue of whether these young mothers catch up as the years pass. The answer is "no." In no instance could we find that even half of the women who became mothers at age 17 or younger completed high school.

Several additional questions need to be addressed.

First, what are the effects of family background and motivation? We found that family background, social class, and educational goals do affect schooling, as you would expect, but that having a child at that age has a critical effect on schooling over and above the effects of the backdrop.

The question of causality is also critical. While I do not want to imply that pregnancy is the only reason girls drop out of school,

among those girls who do get pregnant, the pregnancies seem to increase the chances that the girl will drop out over and above her chances had she not gotten pregnant.

Moreover, without a high school diploma, the young girls' earnings opportunities are limited. They seem to marry men with relatively poor earning prospects, perhaps because the birth forced the father to quit school as well, or perhaps the young mother is not a particularly attractive choice as a wife.

Moreover, having begun childbearing at a young age, by any later age, a teenage mother tends to have a larger family. Among women 35 to 52, in one sample, mothers who were high school age when the first child was born, averaged more than five children compared to an average of close to three.

Also our research substantiates other research regarding the high probability of divorce among couples who marry as teenagers. It has recently been stated that 70 percent of marriages entered by girls 14 and 17 will end in divorce. Consequently, there is a high probability that a teenage mother will be a female household head with children to support. Given her earning ability, poverty is likely. Lower family income presents obvious difficulties to the teenage mother and her family.

An analysis that we conducted for the House Select Committee on Population indicated that Federal and State Governments disbursed $4.65 billion in 1975 through Aid to Families with Dependent Children. To women whose first child was born when they were teenagers, this represents approximately half of the expenditure of about $9.4 billion.

Among women 14 to 30 living in households receiving AFDC, 60 percent had borne their first child while a teenager. Considered from a different perspective, of the women then 14 to 30 who had their first child as teenagers, nearly 20 percent were receiving AFDC.

Although $4.65 billion may sound like a large expenditure, it constitutes an underestimate because it has not been able to include measures of administrative costs, medicaid, food stamps, or the proposed coverage of prenatal care and delivery. In addition, it has not been possible to develop an estimate of the increased cost to the Government due to the health problems of low birth weight infants more frequently delivered by teenage mothers.

In summary, I think that it is fair to conclude on the basis of our research and other studies as well, that teenage childbearing has important negative consequences for the mother and baby and for society as a whole. Reducing the frequency of teenage childbearing should reduce the burden of welfare dependency substantially.

The choice of policy options requires attention to whether or not teenagers wish or intend to become pregnant. Studies show that most teenagers do not intend their pregnancies, and that the cost of contraceptive family planning services is quite low, about $66 per woman for a year or about $225 million a year in terms of Federal appropriations.

Clearly, it is in the mutual interest of Government, individuals and families to help that majority of teenagers prevent pregnancies that the teenagers themselves do not want.

[The prepared statement of Dr. Moore follows:]

THE SOCIAL AND ECONOMIC CONSEQUENCES OF TEENAGE CHILDBEARING FOR WOMEN, FAMILIES AND GOVERNMENT WELFARE EXPENDITURES

Testimony to the Human Resources Committee
of the United States Senate

Kristin A. Moore, Ph.D.
The Urban Institute
Washington, D.C.

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Kristin A. Moore
The Urban Institute

Introduction

During the past decade, the United States has witnessed a dramatic decline in fertility rates. Despite this overall trend, fertility rates have not fallen as rapidly among teenagers as among older women. In fact, fertility rates, while low, are actually rising among females under age 15. The slow decline in fertility rates among teenagers relative to older women combined with large teenage cohorts has resulted in another phenomenon; the proportion of all babies that are born to teenage mothers has risen. In 1950, females under age 20 bore 12 percent of all children and 20 percent of all first children. In 1975, they bore 19 percent of all children and 35 percent of all first children. In addition, the proportion of all births that occur outside of marriage has been rising. In 1975, 14 percent of all babies were born to unmarried women, compared to 4 percent in 1950. Early and out-of-wedlock childbearing tend to be intertwined; 52 percent of all out-of-wedlock births occurred to teenagers in 1975, and 39 percent of teenage births occurred outside of marriage.

Clearly, a significant portion of childbearing in the United States occurs among teenagers, often outside of marriage, and the proportion does not seem to be decreasing. Is this a cause for concern?

This research report focuses on the consequences of early childbearing for the later social and economic status of the mother and her family. Previous research has documented associations between early motherhood and lower educational attainment, a higher probability of divorce among parents who

marry, higher subsequent fertility, and later poverty. However, these associations have not been tested within statistical models that control for important social, economic, and motivational factors. Therefore, it is not clear whether the attainment of young women is inhibited by having a first birth at a young age or whether the achievements of early childbearers are limited by personal and social characteristics other than their age at first birth. Over the past two years, we have been attempting to trace out the social and economic consequences of teenage childbearing using two national surveys--one sample of approximately 5,000 contemporary young American females and one sample of 5,000 households. Our work indicates that teenage childbearing leads to important negative consequences for the young mother and her family. Related analyses suggest that teenage childbearing is also costly for society in general, since an early birth seems to increase the odds that a mother will require welfare assistance.

The economic impact of an early birth is not direct. Rather, it seems to trigger a chain of events that combine to undermine economic well-being. The most critical factor is the reduction in educational attainment that seems to result from a teenage birth; however, subsequent childbearing, lower income on the part of other household earners, and marital instability all play a role. Each of the steps in the process will be considered separately.

Data

The data utilized in this paper are drawn from the National Longitudinal Study of the Labor Market Experiences of Young Women (hereafter referred to as the NLS data), funded by the U.S. Department of Labor, and the Panel Study of Income Dynamics (PSID), funded by the Department of Health, Education and Welfare.

The first wave of the NLS was fielded in 1968 and sampled about 5,000 young women between the ages of 14 and 24. Attempts to reinterview these women were made annually from 1969 through 1973. Sample retention has been very good: by 1972, 90 percent of the original sample remained intact. The NLS data are especially well-suited for a study of the consequences of early childbearing because they follow young women through the teenage and young adult years when family building often takes place. For a large proportion of the sample, data on marriage and childbearing are not retrospective but were gathered as events occurred. Because extensive information was obtained on the education and work experience, as well as on the social and economic background of respondents, detailed comparisons between teenage mothers and young women who postponed their childbearing can be made.

PSID data collection was initiated in 1968 to provide information on short run changes in the economic status of families and individuals. To this end, approximately 5,000 families have been interviewed annually through 1978. Data obtained through 1976 are included in the current analyses. The original sample consisted of a cross-section sample of dwelling units within the continental United States plus a subsample of families interviewed in 1967 by the U.S. Bureau of the Census. Since 1968, the sample has consisted of all panel members living in families that were interviewed the previous year plus newly-formed families that include any adult panel member who had moved out of the sample household since 1968. The addition of newly-formed families has resulted in an increased sample size despite sample attrition. PSID panel losses were considerable in the first year but have been relatively minor in recent years. The data were weighted in 1972 to adjust both for different sample fractions and for different rates of nonresponse. Since that time, attrition has not been sufficiently great to warrant further adjustment.

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and estimates made from the PSID correspond closely with estimates obtained from the Current Population Reports. Nevertheless, as with all survey data, some care is warranted in generalizing from results to the entire U.S. population.

Early Childbearing and Lower Educational Attainment

The importance of schooling to other life outcomes has been documented repeatedly. Income, occupation, fertility, sex role orientation, unemployment, and even the probability of divorce are affected by education (see Moore et al., 1977). Previous research has documented an association between early childbearing and lower educational attainment; however, important factors such as family background have not been controlled for and the issue of causality has not been considered. Since lower status families both complete less schooling and also tend to bear children at younger ages, it is important to control for the impact of family characteristics on education. Otherwise, an effect might be ascribed to teenage childbearing which is really due to family background.

Results from our analyses clearly indicate that early childbearing is associated with significant educational losses. Among the young women age 24 in the NLS sample, for example, girls who bore a child at 15 or younger had completed only 9 years of school on the average. Those who had a first birth at 16 or 17 completed ten and one-half years, on the average.

Early marriage also has a significant negative impact on the years of schooling a young woman is able to complete. It is difficult to sort out the effects of an early birth from early marriage, since they so frequently occur together. However, it is clear that the young woman who both has a child and who marries is the most likely to drop out of school. The young woman who

bears a child but does not marry is only half as likely to drop out as the young woman who becomes both a mother and wife. Whether she marries or not, though, the school-age mother is considerably more likely to discontinue her formal education than a teenager who has not borne a child.

When the effects of factors such as family background, educational goals, and age at marriage are controlled for statistically, young women who had a first birth at age 15 or younger were found to complete nearly two years less schooling than the young women who were still childless at age 24. The impact of teenage childbearing occurs net of these other factors. In every analysis we did, age at first birth was the strongest or one of the strongest influences considered.

Catching Up on Schooling Over Time

We looked at educational attainment among young women in the NLS sample at age 18 and 21, as well as at age 24. Our goal was to examine the possibility that there is an initial loss which is overcome by the young women as the years go by. On the contrary, the young mothers did not seem to catch up with their later-bearing peers. In fact, the gap between the young mothers and the young women who are childless at 18, 21, and 24 increases as the childless contemporaries continue their schooling.

Subsequent analyses on the PSID data suggest that some increases in education do occur even though the young mothers do not catch up. For example, among the PSID women aged 22 to 34, those who became mothers at age 15 or less completed 10.4 years of schooling, compared to 8.9 years among the NLS women. Among PSID women who became mothers at 16 or 17, the mean is 11.0, compared to 10.5 among the NLS mothers. While these are not particularly impressive gains, they do show that some women manage either to return to school, attend adult education, or perhaps pass a high school equivalency examination.

Table 1 portrays this increase in a different manner.

Table 1: Percent of Women Completing Twelve or More Years of Schooling, by Age at First Birth and Race (National Longitudinal Survey and Panel Study of Income Dynamics)

Age at First Birth	NLS Women at Age 24				PSID Women 22-35			
	Black		White		Black		White	
≤15	3%	(33)	7%	(28)	40%	(25)	27%	(11)
16	19	(42)	21	(42)	31	(42)	28	(18)
17	34	(47)	32	(79)	47	(62)	41	(39)
18	48	(48)	63	(136)	64	(53)	65	(48)
19	75	(47)	78	(151)	64	(47)	73	(71)
20	78	(40)	86	(121)	81	(42)	87	(70)
21	67	(30)	87	(110)	92	(26)	87	(46)
22	80	(25)	97	(93)	67	(18)	93	(60)
23	90	(20)	97	(97)	94	(16)	80	(39)
≥24	79	(120)	92	(594)	75	(24)	98	(102)
Childless in 1976	-	-	-	-	86	(57)	99	(158)

At age 24, fewer than 10 percent of the youngest NLS mothers are high school graduates. However, among PSID women aged 22 to 35, 40 percent of the blacks and 27 percent of the whites had managed to secure a high school diploma. This is an important gain, since evidence suggests that women who achieve at least a high school education are only half as likely to live in households receiving Aid to Families with Dependent Children. Nevertheless, in no instance do even half of the women who became mothers at 17 or younger manage to acquire 12 years of education. For most of the young mothers, then, an early birth appears to pose more than a temporary setback to schooling.

The Process of Educational Attainment

Another analysis (see Waite and Moore, 1978) suggests that the factors that are important to the process of educational attainment differ among young women who bear a child during the high school years and those who delay. Among those who postpone childbearing, motivation of the individual and encouragement

or help from others are the most important factors related to years of schooling completed at age 24. However, for teenage mothers, the characteristics of her family are most important. A girl with an advantaged family background--fewer siblings, higher father's education, and an intact family--probably has an easier time coping with the responsibilities of a new baby while also finding it possible to attend school. The impact of the parent's educational goal for her and being in a college prep curriculum are far less important to the teenage childbearer than to the childless teenager, presumably because the realities of motherhood make it difficult for her to realize previous goals, whatever they are.

Race

In the NLS analyses, after controlling for age at first birth, family background and motivational factors, the young woman's race has only a tiny and non-significant effect on schooling. Yet we know that teenage childbearing has an impact on educational attainment and that early childbearing is considerably more common among blacks in the United States. Further analyses were therefore conducted for blacks and whites separately, with interesting results.

We had hypothesized that black females would suffer less of an educational disadvantage from adolescent childbearing than their white peers. Since teenage parenthood is much more common among blacks than among whites, social mechanisms for dealing with this occurrence seem likely to be better established in black families and neighborhoods or in school systems with a high proportion of black students. Other evidence suggests that the presence of babies and young children interrupts the lives of black women less than those of white women. In line with this reasoning, we do find that early childbearing has far less effect on educational attainment among blacks than among whites.

In fact, by age 24, a first birth at age 15 or younger results in twice the educational loss for young white women that it does for young black women--3.1 versus 1.4 years of schooling. At every age for first birth, the effect is smaller for blacks than for whites. (See Moore et al., 1977 or Moore and Waite, 1977, for detailed results). The specific mechanisms underlying this relationship are not known at this time. However, subsequent exploration of this issue on a different national data set (the Michigan Panel Study of Income Dynamics) confirms not only the negative impact of an early birth, but the finding that the negative impact is greater among whites than among blacks (Moore et al., forthcoming). This is not to suggest that among blacks early childbearing poses no costs, only that the costs are somewhat less severe than among whites.

Causality

Another critical issue is that of causality. Does the early birth cause school drop-out, or do young women simply drop out and then become pregnant? Cross-tabulations of age at first birth by age at termination of schooling indicate that only among childbearers aged 18 or under does either pregnancy or childbearing precede school drop-out in a substantial number of cases. Of those young women who have a first birth while 16 to 18, for example, 70 percent drop out of school within a year of that birth (either 1 year before, in the same year, or in the year following). Of those who have a first birth between 19 and 21, only 25 percent finish schooling within one y ar of the birth. With our data, we cannot pinpoint the timing of pregnancy and drop-out. To explore this issue, we estimated a causal model specifying simultaneous causation between age at first birth and education. That is, we hypothesized that age at first childbirth affects the years of schooling completed and vice versa, that schooling affects age at first birth. We evaluated this model

first among women having a child at age 18 or younger, second among women having a child between ages 19 and 26, and finally among all young women having a birth by age 26. (See Hofferth and Moore, 1978).

As expected, the effect of the age at which a woman bears her first child on educational attainment is very strong if she has that first birth while still in high school. In our sample, the number of years of high school a girl has finished has no reciprocal effect on the age at which she bears that first child. In other words, our analysis indicates that the causal direction is from childbearing to schooling among mothers of high school age. Among older mothers (and within the total, combined sample), causality was found to flow in both directions. That is, age at first birth affects years of schooling completed; and years of schooling completed also affects age at first birth, although the latter effect is stronger among older mothers.

Summary

In sum, our results indicate that an early birth affects the amount of schooling a young woman is able to complete, even when family background and motivation are controlled. Moreover, our anlaysis supports the view that an early birth plays a causal role in school drop-out. We do not wish to imply that all or even most drop-outs are due to pregnancy (since two-thirds of the drop-outs in our study appear to have had other reasons). However, among those girls who get pregnant, the pregnancy seems to greatly increase the chances that a girl will drop out over what her chances would have been if she hadn't gotten pregnant.

Subsequent Childbearing

Having begun childbearing at such an early age, teenage childbearers tend to have larger families by their mid-twenties than women who delay childbearing. For example, in the NLS analyses, we found that by age 24, the woman

who began childbearing while 15 or younger has an average of 3 children. In a later analysis on the Panel Study of Income Dynamics (PSID), we were able to look at older women, to get a better picture of completed childbearing. Among women in the PSID study aged 35 to 52 in 1976, we find early childbearers continue to have far larger families than women who were at least 20 when they began family building. Women 17 or younger at their first birth bore over 5 children each, on the average, while women who were at least 20 had an average family size of closer to three.

Table 2: Mean Number of Children by Age at First Birth, by Race (Mothers Aged 35 to 52 in 1976--Panel Study of Income Dynamics)

Age at First Birth	Total (n)	Whites (n)	Blacks (n)
≤15	5.3 (19)	5.9 (10)	4.6 (9)
16-17	5.5 (164)	5.6 (144)	5.1 (20)
18	4.0 (91)	3.9 (75)	4.6 (17)
19-20	3.9 (300)	3.8 (263)	4.0 (37)
21-23	3.4 (363)	3.3 (338)	4.0 (25)
≥24	2.5 (502)	2.6 (370)	2.2 (132)

In the table above only race is controlled; however, we have found that the association between an early first birth and high subsequent fertility holds and is statistically significant even when one controls for religion, parental status, the number of siblings the woman had, farm background, southern background, employment with young children in the home, age at marriage, education of the woman and premarital timing of the first birth. Work by other researchers substantiates this association between early and high fertility (Truesel and Menken, 1978; Suchindran and Teeter, 1978). Thus, whatever initial difficulties the teenage mother experiences due to an early birth and reduced educational attainment, it appears they are frequently compounded by subsequent high fertility.

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Marriage, Divorce, and Female-headed Families

Our work, in line with numerous other studies (e.g., Glick and Norton, 1977; Bumpass and Sweet, 1972) suggests that teenage marriages are particularly unstable. We explored whether it is an early birth or simply early marriage that is the predisposing factor, and found that teenage marriages are highly prone to disruption, regardless of age at first birth. The high probability of marital disruption among teenagers who marry -- Glick and Norton (1977) estimate that 72 percent of teenage marriages eventually break up -- suggest that marriage is not necessarily in the interest of the pregnant teenager, at least from the perspective of forming a stable family unit. It also suggests that whether the teenage mother bears a child outside of marriage or within marriage, the chances are high that she will spend some time as a female family head. Given her low educational attainment, she will probably be an impoverished female head.

A Causal Model of Social and Economic Attainment

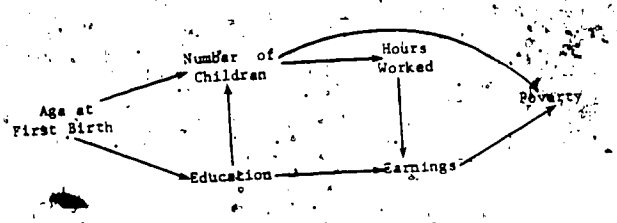

Figure 1: A Causal Model of the Effects of Age at First Birth

Our perspective on the consequences of an early birth is that the effects must be viewed as part of an ongoing process (see Figure 1). One important link is the lower educational attainment of teenage mothers, and to a lesser extent, of teenage fathers (Card, 1977). A second link is the teenage mother's

larger family size, which not only makes it more difficult for a mother to work but also requires that the total family income, whatever it may be, be shared among a larger number of persons. Moreover, a teenage mother is more likely to be the sole earner, either because she has not married or because her marriage has ended. We also find that teenage mothers later have lower earnings because of their lower educational attainment, which is, as we have seen, affected by their age at first childbirth. Because of their larger family size, teenage mothers tend to work fewer hours. Net of family size, however, they work more hours, presumably due to economic need.

In the short run, because these several effects go in different directions, they seem to cancel out. Early childbearers tend to work fewer hours because of their large families and to earn less because of their low educations. On the other hand, controlling for these other factors, they tend to work longer hours which has an offsetting effect. However, the other earners in the young mother's household, including her husband if she is married, tend to have lower earnings. Overall, therefore, these families work longer hours to achieve lower incomes which must be divided among larger families.

In dollar terms, the young women in our study were better off at age 27 by $153 (in 1976 dollars) for each year that they postponed their first child. Their probability of being in poverty fell by an average of 1.6 percentage points per year of delay, a substantial reduction in a sample in which only 12 percent overall are in poverty.

Looking at only that sub-group who had children at age 18 or younger, it is clear that the effect of delaying first births among these early childbearers can be very large in dollar terms. For each year a high school student can postpone her first birth, she can expect to complete, on the average 4/5 years of further schooling. By age 27, this schooling will raise her earnings by $73 for each year of delay (in 1976 dollars). In addition,

other earners in her household will contribute $1220 more, for each year of delay. This cumulates to a household that is better off by $1293. Expressed another way, the probability that her household will be in poverty is reduced by 2.5 percentage points for each year of delay (in a sample in which the average percent in poverty is 12.0). Therefore, if teenage childbearing can be delayed in favor of further education, the economic advantages and associated non-economic advantages, to the individual, her family, and society, appear to be substantial.

Consequences of Teenage Childbearing for the Aid to Families with Dependent Children Program

All of the analyses discussed so far suggest that early childbearing increases the chances of being poor later in life. This in turn suggests that teenage mothers are especially likely to require welfare support. To explore this issue, we have estimated the expenditures of the federal and state governments through the Aid to Families with Dependent Children (AFDC) program to households in which the mother was aged 19 or younger at the time of her first birth.

Data for Study of Aid to Families with Dependent Children

The data used for this analysis are the March, 1976 Current Population Survey of nearly 50,000 households, conducted by the United States Census Bureau. Since information about women's ages when they bore their first child was not gathered, it has been necessary to impute this information by subtracting the current age of the woman's oldest child from her own current age. Because children outside of the household were not enumerated, we cannot produce an accurate measure of age at first birth for those women who might have older children. Consequently, women older than 30 have not been analyzed directly. In addition, children given up for adoption, children who die, and children living apart from their mothers are not counted. Therefore,

we will be describing that sub-set of women who were 14 to 30 in 1976 who have their own children living within their household.* We have, however, made estimates for older women, in order to produce estimates for the entire population.

Estimated AFDC Payments

Our analysis indicates that the federal and state governments, disbursed 4.65 billion dollars through AFDC in 1975 to households containing women who bore their first child while teenagers. This represents nearly half (49.7 percent) of a total AFDC expenditure of about 9.4 billion dollars.[1]

Although 4.65 billion dollars may seem like a large expenditure, it constitutes an underestimate because it has not been possible to include measures of administrative costs. In addition, expenditures on other programs such as Medicaid (which averaged $161 per child yearly in 1975)[2] and food stamps (which averaged $2,266 per household yearly in 1976)[3], or the proposed coverage of prenatal care and delivery (estimated to cost $1,135 per pregnancy in 1976 dollars)[4] have not been added in because no information is known on their use by teenage mothers. In addition, it has not been possible to develop an estimate of the increased costs to the government due to the health problems of low birth weight infants more frequently delivered by teenage mothers.[5]

Overall, among women 14 to 30, of those in households receiving AFDC, 61 percent had borne their first child while a teenager. (See Table 3.)

*In multi-family households, each family was designated as a household.

Table 3: Age at First Birth of Women Age 14-30 Living in Households Receiving AFDC Payments in 1975 (Percents)

Age at First Birth	Percent of Recipients in Age-at-first-birth Category	Percent of Non-Recipients in Age-at-first birth Category
≤15	6%	3%
16-17	21	9
18-19	34	23
≥20	39	65
	100%	100%
≤19	61%	35%
≥20	39	65
	100%	100%

The proportion differs greatly by race, as can be noted in Table 4.

Table 4: Age at First Birth Among Women Living in Households Receiving AFDC Payments in 1975, by Race

Age at First Birth	White	Non-White
≤15	3	10
16-17	18	28
18-19	34	33
≥20	44	29
Total	100%	100%
≤19	56	71
≥20	44	29
Total	100%	100%

Another way to explore the issue is to examine the proportion of women aged 14 to 30 who live in households receiving AFDC, by the age of the woman at her first birth. In general, the older the woman at her first birth, the less likely she is to receive AFDC, although the very youngest mothers are less likely to receive AFDC than those aged 16 to 17 at their first birth. This may occur because the very youngest mothers are less likely to marry, more likely to remain with their own parents, or less likely to bear full responsibility for child care, therefore actually ending up more advantaged later in life than the teenager who is slightly older. Again, a pronounced race difference is apparent, with white mothers far less likely to need to rely upon welfare support. (See Table 5.

Table 5: Percent of Women 14-30 in 1976 Living in Households Receiving AFDC Payments, by Age at First Birth and Race

Age at First Birth	White	Non-White	Total
≤ 15	18%	43%	27%
16-17	24	48	31
18-19	18	43	22
≥ 20	9	22	10
≤ 20	19	45	25
≥ 20	9	22	10

The importance of educational opportunities is indicated by the results in Table 6. Although even those young mothers who complete high school are more likely to live in households receiving AFDC than later childbearers, they are far less likely to require assistance than their peers who do not complete high school. This would suggest that programs aimed at assisting young mothers to complete high school are a good investment for the government, as well as for the individual.

Table 6: Percent of Women 14-30 in 1976 Living in Households Receiving AFDC Payments by Age at First Birth and Education (women with children)

Age at First Birth	Education	
	Less than High School	High School or More
≤ 15	36%	15%
16-17	36	20
18-19	31	17
≥ 20	25	8
Average Percent	31	11

One hopeful sign is suggested by Table 7. As women become older, they are less likely to require AFDC support. Although early childbearers remain considerable more likely to live in households receiving AFDC, within each age at first birth grouping the proportion receiving AFDC declines as women age. Perhaps as children become older, women find paid employment more feasible.

Table 7: Percent of Women Living in Households Receiving AFDC Payments By Age at First Birth and Age in 1976 (Women with Children)

Age at first Birth	Age in 1976			
	20	20-24	25-30	Total
< 15	34%	29%	23%	27%
16-17	39	33	25	31
18-19	27	26	17	22
≥ 20		16	9	10
Average Percent	33	22	12	16

Conclusions

The choice among policy options requires attention to whether or not teenagers wish or intend to become pregnant. Studies show that most teenagers do not intend their pregnancies (Zelnik and Kantner, 1974, 1978) and that the cost of contraceptive family planning services is quite low--about $66 per woman for a year[6] or about $225 million a year in terms of federal appropriations.[7] Clearly, it is in the mutual interest of government, individuals, and families to help that majority of teenagers prevent pregnancies that the teenagers themselves do not want. To do this, we need:

(a) to provide contraceptive services for teens as a form of preventive medicine. Special programs are probably necessary: clinics with hours in the evenings and on Saturdays, clinics that are near public transportation and are low cost but also private and pleasant.

(b) We need sex education in schools and sex education on public TV, where families can view programs together if they choose.

(c) We need to address attention toward the teenage male. We know little about his attitudes, motivations. The condom is a good contraceptive for teens, one that prevents VD as well as pregnancy, but promotion of the condom requires male involvement.

(d) We need changes in laws to permit the sale of non-medical contraceptives and pregnancy testing kits over the counter.

(e) We need special training workshops or booklets for physicians who provide services to adolescents to help practitioners improve service delivery and communication skills.

(f) We need to sponsor research to evaluate the contentions that family planning causes teenage sex, that sex education encourages promiscuity, that teenagers have babies in order to go on welfare, because these beliefs undermine efforts to provide services.

For those teenagers who intend their pregnancies, or who do not care whether they become pregnant, we need to clarify for them the costs of early childbearing. In addition, it may be the case that the reason that they do not care is that they lack really attractive alternatives that make them wish to delay childbearing. Indeed, the attention, status, and affection associated with pregnancy and motherhood may provide strong incentives to become pregnant. If we wish to encourage unmotivated teenagers to postpone parenthood at least until they have achieved a high school education, the provision of attractive alternative opportunities for women as well as men will require attention and action. These alternatives may be educational or occupational. A reduction in the high rate of teenage unemployment, for example, and an end to sex and race discrimination represent basic steps to the provision of alternate opportunities. We need to not simply search for the perfect contraceptive, but to study the motivation for contraception as well.

Finally, we cannot ignore the needs of those teenagers who do become parents. We need to stress generally the importance of pre-natal care in the first trimester and concomitantly, early pregnancy detection. We need to develop counseling strategies for pregnant teenagers that stress the well-being of the child in the parent's decision about marriage and adoption. For those teenagers who decide to keep and rear their child, we need to provide infant day care and parenting education. The teenage parent also needs assistance in completing high school. Despite the enormous cost of such programs, they are likely to pay off economically if they

enabla young parants to avoid long tarm welfare dependency. The non-economic benefits should also be great.

Most of all, we should not delay nor deny funds that are critically needed. Preventing the negative social and economic consequences of teenage childbearing is far less costly in every sense than pasaively accepting those consequences.

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Reference Notes

1. Payments to households of women aged 14 to 30 were computed by the Trim Model (See Technical Appendix) of the Urban Institute, Washington, D.C., to total $3.8 billion, of which $2.4 billion was expended on households of women who had a birth before age 20. Of a total 1975 AFDC bill of $9.4 billion, then, a remainder of $5.6 billion was expended on women older than 30 in 1976. Since smaller proportions of teenage mothers were found among older AFDC recipients, (48% among women 25-30 were teen mothers, versus 55% among women 20-24), $5.6 billion was multiplied by an even smaller proportion—.40—to produce an estimate of the AFDC bill expended on women who first became mothers while teenagers among women past age 30 in 1976.

$2.4 billion + (.40 X $5.6 billion) = $4.65 billion

If the true proportion were only .30, then the amount expended for households in which the woman became a mother as a teenager would be reduced only to $4.08 billion, which would not alter our substantive conclusion.

$2.4 billion + (.30 X $5.6 billion) = $4.08 billion

2. "Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Year 1966-1977," Table 61, page 83.

3. Department of Agriculture, personal communication.

4. Kugelman, Robert, "Estimated 1976 Medicaid Reimbursement for Maternity Related Care," Department of Health, Education and Welfare, unpublished, April, 1977. (Estimate is for Medicaid reimbursement rather than the actual cost of pre-natal and obstetrical care.)

5. Menken, Jane, "The Health and Demographic Consequences of Adolescent Pregnancy and Childbearing," paper presented at conference on adolescent childbearing, National Institute for Child Health and Welfare, October, 1975. Also Joel Kleinman, Division of Analysis, National Center for Health Statistics, personal communication.

6. Sherry Silverglade, Alan Guttmacher Institute, unpublished data.

7. According to Planned Birth: The Future of the Family and the Quality of American Life (June 1977) National Family Planning Forum, Washington, D.C., the monies appropriated by the federal government—not necessarily even spent—were as follows in 1977:

Title X	$113.5 million	grants to public/private non-profit agencies (excluding monies for research or abortion)
Title V	25.0 million	formula grants to state health agencies
Title XIX	37.0 million	Medicaid
Title XX	49.7 million	$30 million for Social Services (purchased medical services) and 19.7 million for casework and referral
	225.2 million	

Senator RIEGLE. Let me just make one comment and ask you one question before moving to our last witness.

If I heard your statistics correctly, roughly half of the AFDC moneys that the Federal and State Governments now pay out, something on the order of $4.5 billion a year, go to women who had their first child as a teenager.

Dr. MOORE. This is correct.

Senator RIEGLE. Did you say below 17 or as a teenager?

Dr. MOORE. As a teenager.

Senator RIEGLE. I think that is a highly relevant statistic in light of everything else that we have seen, in light of the tremendous cost that is associated with assisting women and their children in this circumstance. And I think we have every reason, starting with the obvious humane arguments of decency, but also in terms of Federal Government dollars, to come up with ways to see if we can help teenage women face these circumstances.

I know in my travels through Michigan, talking to women on the AFDC, they were looking for ways to get off. It is a rare situation where you find someone who wants to stay there. Inevitably, they say that they hope jobs will become available, or day care centers that will allow them to break out of that cycle of poverty and become self-sufficient.

But it seems if we avoid this problem and look the other way, then we shepherd the young women in that dead end situation that so many are in.

Let me ask you one question. Apparently 15 to 20 years ago, the vast majority of unwed mothers tended to give their babies up for adoption, whereas today, the statistics indicate that approximately 90 percent of the girls now decide to keep the baby. That to me is a very profound shift in thought and practice. And I am wondering what you think may have caused the reversal in this trend?

Dr. MOORE. We might all want to speak to that. For one thing it has become much more acceptable to keep the child, to rear it themselves in a social sense.

Dr. BALDWIN. I do not think we know the extent to which placing a child for adoption ever was a preferred solution. We see now that, by and large, women who have out-of-wedlock births prefer to keep the child with them and to take on the role of the mother even if they are not ready to take on the role of the wife.

Senator RIEGLE. Do we have any information that shows though how they feel about that decision about 2 or 3 years later?

Obviously, if you keep the baby, then, 2 or 3 years later, you find that because of the enormous struggle and adversity of one kind or another, you feel at that point that perhaps 2 or 3 years before you ought to have given the baby up for adoption, someone might have been in a better position to care for it. I can imagine it is very hard for a young woman to say that particularly when it relates to the baby that she has had, and it is now 2 or 3 years old.

Have we been able to get to that question?

Dr. BALDWIN. The baby may be placed for adoption at a later date. I have heard stories that there is increase in the extent that women are placing the child up for adoption when he or she is 4 years old.

I have not been able to substantiate that, but I have heard from a number of sources.

Ms. FORBUSH. The same type of anecdotal information has been provided to our organization by several of the agencies that are working with pregnant adolescents and young parents. It suggests that after the adolescents have had an opportunity to experience parenting, the frustrations and difficulties come home very clearly. Social workers and others who are working with them after they have delivered have reported as I said, anecdotally, that increasingly they are finding that young women and sometimes couples are asking what can be done about placing their youngster now?

Senator RIEGLE. It is almost an impossible situation, particularly in the case of the young woman who is alone, who has to shoulder this responsibility. And I can see why, just based on increasing social acceptance and the facts that attitudes have shifted somewhat from what they have been a decade or so ago, that there is probably a greater tendency for young woman to want to keep the baby. Yet I am sure that the trials and tribulations have not really changed.

In most cases, they are bound to face impossible problems in those early years of trying to raise a child and attend to all these other things, to try to acquire job skills, to get situated and some sort of independent footing and so forth. And I think this underscores the need for the kinds of services that are contemplated in this bill to see if we can, first of all, help prevent those kinds of pregnancies from occurring, and should they occur, then to assist people in facing up to their reality and making the best decisions they can to fit their own circumstances.

Let us, at this point, move to you, Ms. Forbush.

Ms. FORBUSH. I am Janet Forbush, and I am the executive director of the National Alliance Concerned with School-Age Parents (NACSAP), which is a nonprofit, multidisciplinary membership organization established in 1969 to address three major issues.

One is the need for services for youngsters and their families who are already involved in pregnancies. Another aspect of our program addresses the needs for creative primary prevention strategies, and ultimately NACSAP tries to bridge the gaps between those two different types of programs.

I am happy to be here to testify on this measure, and since you have assured us that our testimony will be incorporated into the record, I will move to a summary that touches on some points which perhaps are not as well articulated in S. 2910 that we feel need to be addressed.

In effect, NACSAP, as I mentioned, has been primarily focusing on the needs of youngsters who are already pregnant, or who are young parents, and in findings way to develop service programs that are comprehensive to meet their needs.

One of our concerns about this particular measure is that it suggests that a $60 million startup program would be able to realistically address primary prevention, as well as the treatment of young people who are already experiencing a pregnancy.

We feel that the strength of this measure is that it speaks primarily to the needs of a population, which to a great extent have gone unserved and unmet. We feel that if indeed the primary emphasis of

this bill, and the expenditure of the dollars that might come along with this measure were to be directed toward those young people who are already pregnant, or who are already young parents, that it would be a meaningful first step toward serving them.

We heard this morning that cost estimates developed by the Department of Health, Education, and Welfare suggest that $750 per student per year is a realistic estimate with respect to developing long-term cost estimates for this program.

In light of the fact that there are really very few comprehensive service programs throughout the country, in fact, our estimate is that at best a couple of hundred might be considered comprehensive in the broad sense, this estimate of $750 must be explained. Even the programs to which I am referring probably do not include all of the elements that are recommended for a comprehensive program.

In effect, that $750 estimate needs to be examined very carefully, and we need to be sure it is a realistic estimate of comprehensive program costs. To some extent our concern is predicated on the fact that at least two services are not as carefully spelled out in S. 2910 as they need to be.

One is the need for quality developmental infant day care for young people, after they have had a baby.

Interestingly enough, on the basis of a survey NACSAP conducted in 1977 for the Joseph P. Kennedy, Jr., Foundation, a survey of 50 programs throughout the country which provide a range of services for impacting on the needs of pregnant adolescents and young parents, we found that all of those agencies indicated there was a great need for support to help develop infant day care services.

A second element that we found to be missing in the programs was the followthrough. After a young woman, and perhaps her husband, or partner, have experienced a pregnancy and have chosen to keep the child and be parents, they need people to talk to who understand the difficulties they are facing. They need people who are going to reach out to them and assist them in establishing contact with the incredible web of services existing in most communities in this country.

An assumption underlying S. 2910 suggests that if funds are available to link services, that we can make a sizable impact on this incredibly complex social problem.

It is our experience in working with approximately 1,500 programs throughout the country that in some communities services are not, in fact, available to link.

Second, in order to start up a program, the development cost might indeed be greater than we have been led to believe today in earlier testimony. Therefore, we feel strongly that it is important to recognize the difference between startup costs or development costs and funds that are needed to link existing services.

At best, I think NACSAP would describe the picture of services in this country as a patchwork quilt. I have had the opportunity to visit approximately 100 adolescent parent programs around the country, and I would venture to say that I have yet to see a model program.

We heard testimony today from representatives and service providers from some very good programs, but even they themselves admit that there are aspects that they are not able to address as ably as they

would like. For example, I go back to the need for quality developmental day care services as well as services that would take into account the needs of total family units.

Another point I would like to raise is the issue of the evaluation mechanism that will be incorporated into the implementation of this program if it is started. We feel strongly that this is an especially important part of this program, and we therefore recommend that more than 1 percent of the $60 million authorization be used for evaluation.

Based on the limited number of studies which document what has happened to young people who have participated in adolescent parent programs, not enough information to guide us in shaping a long-term program into the future. More evaluation data needs to be made available, and criterion need to be developed so that people who are developing programs and expanding existing efforts will be confident that they are cost-effective as I know you wish them to be, and as service providers want them to be for their communities.

The next point that I raise is very close to home in terms of the work of the National Alliance Concerned with School-Age Parents.

When we were started in 1969, we were viewed as a technical assistance organization, and that is yet today our primary focus. Based on our experience and the types of requests that we generate regularly from local, State and Federal agencies, we know that the needs for technical assistance are a major part of this program. Technical assistance must be available to help the Department of Health, Education, and Welfare get such an effort ably underway and to also help States in conducting needs assessments and assisting local communities address their needs.

This will be a pivotal factor in assuring the success of S. 2910 if it is passed. Technical assistance takes lots of forms and one of the forms that we have been providing relates to inservice preservices training for professionals and others who work directly with pregnant adolescents, sexually active teenagers, and young parents.

Unless it is an unusual community, a community that perhaps we have not had contact with, it is our experience that it is the exception, rather than the rule, that people automatically understand as professionals and parents how to deal with this incredibly difficult issue, and therefore, the need for inservice and preservice training cannot be overemphasized.

We have conducted inservice training programs in several States, some of which have been held in concert with institutions of higher education. We have used consultants—consultants who have been proven experts in this area. To that extent, we feel that the restriction in S. 2910 with regard to using institutions of higher education, and also consultants, would perhaps undermine, or negate some of the beginning efforts that have already been made in this area.

We would recommend that a waiver clause be included in that section of the bill so that as communities are looking at ways to develop technical assistance strategies including inservice training programs, that based on a review of the proposed curriculum and the faculty to be involved, that would be permitted to engage in work in concert with the institutional programs that are already in place, and also expert consultants.

Senator RIEGLE. If I may, I am going to have to ask you to conclude. It is not because I do not want to be able to listen to more of what you have got to say, but it is just necessary that we do it that way.

Ms. FORBUSH. All right.

My last two points relate to the proposed means whereby this program would be implemented, and carried out under the leadership of Secretary Califano, and the persons in the Department of Health, Education, and Welfare.

We feel that a key part of this program is predicated on the coordination of the health, education, and social service components of the program, whether that is at the Federal, State, or local levels.

To the extent we feel that it would be helpful, and important for the Department to involve the use of an advisory committee that is comprised of people from several different disciplines outside the Department, who have expertise in this area.

Given its complexity, and the scope of the problem, we feel that an advisory committee would help insure the success of the program.

Thank you very much.

Senator RIEGLE. I appreciate all of your comments.

[The prepared statement of Ms. Forbush and material subsequently supplied for the record follows:]

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nacsap

National Alliance Concerned with School-Age Parents

7315 WISCONSIN AVENUE, SUITE 211-W
WASHINGTON, D.C. 20014

JANET BELL FORBUSH
EXECUTIVE DIRECTOR

TESTIMONY

of

JANET BELL FORBUSH

EXECUTIVE DIRECTOR, NATIONAL ALLIANCE CONCERNED WITH SCHOOL-AGE PARENTS

on

S. 2910

ADOLESCENT HEALTH, SERVICES, and PREGNANCY PREVENTION and CARE ACT of 1978

before the

SENATE COMMITTEE ON HUMAN RESOURCES

June 14, 1978

I am Janet Bell Forbush, Executive Director of the National Alliance Concerned with School-Age Parents (NACSAP), a non-profit, multidisciplinary membership organization established in 1969 for the purpose of providing technical assistance to those who are working with pregnant adolescents, school-age parents, sexually-active youth and their families. NACSAP's membership is comprised of nearly 2,000 educators, social workers, health care providers, youth workers, researchers and policymakers from 47 states and the District of Columbia who are, for the most part, associated with state and community based service programs in urban and rural areas. Through its membership NACSAP is in contact with over 1,500 programs which offer an extensive though inconsistent array of support services to pregnant teenagers ranging from comprehensive approaches to beginning efforts which might only provide a single service at this time.

NACSAP is greatly encouraged that this Administration recognizes the seriousness and complexity of the phenomena of adolescent sexuality, pregnancy and parenthood. Our organization is also encouraged that the Administration has introduced legislation which, if passed, would assist states and communities in responding to families that need considerable help and understanding. As the only national organization devoted exclusively to the development of comprehensive programs and policies focusing both on the reduction in incidence of high-risk, unwanted pregnancies among teenagers and in the provision of essential support services for adolescents who carry pregnancies to term and become parents between the ages of 9 and 18, NACSAP is acutely aware of the critical need for this type of aid. It is, therefore, a pleasure for me to

appear before the Committee today in general support of S. 2910. I also wish to express our appreciation to Senator Edward Kennedy for his leadership and continued interest in this issue. Because of the uniquely relevant experience of NACSAP's members, my testimony is intended to articulate observations and questions about S. 2910 which will hopefully help stengthen the measure and thereby assure the likelihood of it having maximum impact on this compelling problem.

The Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978 is apparently intended to address three major concerns: 1) the need for general age-appropriate health services for adolescents; 2) primary pregnancy prevention services for teens; and 3) comprehensive treatment services for adolescents who are pregnant and/or have already had children. While all of these needs are important, on the basis of NACSAP's experience with those programs that are serving predominantly pregnant adolescents and young parents, it would be unrealistic to expect a $60 million dollar program to respond adequately to all of these areas. Therefore, since S. 2910 represents only one element of the Department of Health, Education, and Welfare's proposed Teenage Pregnancy Initiative and, in light of recent passage of family planning legislation which includes funding for services intended for adolescents, NACSAP recommends that the primary--though not exclusive--emphasis of this bill be on the needs of pregnant adolescents, young parents, their infants and extended families. It is this population which has been undereserved or inserved in most communities and it is this group of families whose needs are so comprehensive as to be overwhelming. We view S. 2910

as a beginning effort to meet the needs of this group of citizens and, if so directed, it would be a strong foundation upon which to build in successive years. The concept of a long-term program is, of course, predicated on the realistic assumption that regardless of the effectiveness of primary preventive strategies, there will continue to be some adolescents who bear children and who will therefore need comprehensive services to ensure the delivery of healthy babies and go on to realize their full life potential.

For the immediate future, it is our recommendation that the second and third years of this program be assured of authorizations of no less than $90 and $120 million respectively in order to provide existing programs with needed support to develop components not presently offered and to aid in the establishment of services in communities where support is not yet available. We are confident that if this element of the Teenage Pregnancy Initiative were to be funded at these levels, the current average of approximately 15% of pregnant adolescents and young parents who are in need of special consideration and who are currently served by existing agencies would be increased measurably. Incidentally, the estimate that 15% of the pregnant adolescent and school-age parent population is now being served, at least in part, is derived from a 1977 NACSAP survey of 50 programs. More detailed reference to that survey is made in subsequent paragraphs. However, I would emphasize that the nature of information available from school-age parent service providers is generally unsophisticated and lacks the precision of data available from health and/or family planning information systems.

In addition to concern about the level of funding proposed for S. 2910, given its extremely broad focus, NACSAP questions what

appears to be a basic assumption underlying the measure which implies that services are, in fact, available to sexually-active youth, pregnant adolescents and young parents but for some reason or reasons have yet to be linked together for the purpose of impacting on the issue of adolescent pregnancy. Based on a survey of 50 urban and rural community agencies which NACSAP conducted last year for the Joseph P. Kennedy, Jr. Foundation, it was possible to conclude that the pattern of services is at best a "patchwork quilt" with very few comprehensive programs in place largely because essential services are either not available or are virtually inaccessible for the agency in question. The intent of this survey was to obtain information on the extent to which health, education, and social welfare agencies were responding to the needs of pregnant adolescents and young parents; to identify sources of financial support for services presently offered; and to identify gaps in those services. To carry out the project, NACSAP classified the agencies according to the variety and extent of services they offer and selected participating agencies on the basis of a stratified random sample technique. Class A agencies were those providing health, education, and social services to adolescents during pregnancy and for a clearly defined period postpartum. Class B agencies provide services in any two of the above categories and Class C agencies offer support in one of these areas only. Within the social services category, infant and child day care was included as a primary service requirement.

The basic data collection method was an extensive questionnaire followed up in 40 of the 50 communities by a site visit from NACSAP staff or a consultant. Anecdotal information was also obtained

during the site visits to augment the standardized questionnaire. The findings of this survey along with the findings of a 13-state school-age parent needs assessment project conducted by NACSAP in 1975 suggest that a general assumption that basic services are already in place for young parents and only needing to be coordinated is misleading. While this is possibly the case in large urban areas, it is by no means the standard in suburban and rural communities. In fact, in rural and suburban communities, attitudinal issues are just beginning to be dealt with which necessarily precedes the advent of services. Funds for use by state and local agencies for purposes of coordination and linkage will, no doubt, be helpful. Nonetheless, funds for the purpose of linking existing services will not supplant the need for services not yet in place.

By way of illustration, all of the agencies that participated in the 1977 NACSAP survey identified infant and child day care as a resource that was critically needed but which was unavailable regardless of the location of the program in an urban or rural area. Other services which the participating agencies viewed as essential but which were largely unavailable as of the spring of 1977 were: group homes and/or residential care for young women who are unable to remain with their families during the pregnancy; services for adolescent fathers; comprehensive school health/sex education/family life/ parenting education courses; decisionmaking training for adolescents; transportation; and long term follow-through for a minimum of two years following delivery. With respect to follow-through services, providers have indicated that to effect this dimension of a program, it is essential that staff be available to engage in pro-active out-

reach with clients or students with whom they have had previous contact in a special program. However, since resources have been limited in terms of those young people who are pregnant, limited attention has been focused on long term follow-through. Yet, follow-through is a central factor as a means of reinforcing the concepts and training of special prenatal programs including re-emphasizing the considerations for young people to make to avoid early, unintended repeat pregnancies.

The services identified above are those which agency staff reported to be available only to a minimum degree among service providers participating in the 1977 survey. These services, however, do not by themselves represent the core support which NACSAP recommends as a comprehensive approach for meeting the needs of pregnant adolescents, young parents and their families. What are these core services? The three key components of a core services approach--each of which is an integral part of any comprehensive strategy--are health, education, and social services. Listed below are the chief elements included in each of these areas. All should be available to pregnant adolescents, young parents and their families during the course of a pregnancy and for a minimum of two years following delivery but will be used by consumers on the basis of individual needs.

CORE SERVICES

A. CLIENTS

HEALTH COMPONENT

- General age-appropriate adolescent health services (includes dental and eye care)
- Pregnancy Testing
- Prenatal Care/Preparation for Labor & Delivery
- Nutrition Information
- Family Planning Counseling and Services
- Pediatric Care

EDUCATIONAL COMPONENT

- Regular academic school curriculum (A comprehensive parenting/health/sex/family life education course is included in NACSAP's concept of a regular academic curriculum)
- Vocational Training/Job Placement
- Consumer Education
- Decisionmaking Training

SOCIAL SERVICES COMPONENT

- Individual and Group Counseling These services are intended to introduce all available options to pregnant adolescents regarding disposition of suspected or confirmed pregnancy. (NOTE: This is an important element insofar as adolescent fathers and extended family units are concerned.)
- Developmental Infant/Child Day Care
- Legal Services
- Group Homes/Residential Care
- Transportation
- Financial Assistance (Includes reference to AFDC/MEDICAID support)
- Adoption Services
- Psychological/Psychiatric Services

B. SERVICE PROVIDERS

Regular in-service and/or pre-service training for administrators and staff associated with programs serving sexually-active youth and young parents. (Basic training courses constitute technical assistance that would help staff develop skills in communicating with young parents and their families; alert administrators to funding sources and regulations affecting programs; and, suggest means to document efforts, develop linkages, promote public awareness, and develop research designs.)

It is easy to see why comprehensive school-age parent programs are frequently an administrative enigma in view of the range of elements that need to be included in such efforts. However, attention to detail is important when relating to adolescents. A point I would like to make, and one which the health-oriented focus of S. 2910 does not highlight is that the Core services concept incorporates health, education, and social services as equal partners in comprehensive program efforts. Recognition and respect for the equality of this partnership at the federal level will, in our opinion, facilitate the cooperation of personnel from all these disciplines at state and local levels and will help achieve successful outcomes for this program. If, however, S. 2910 is interpreted and ultimately implemented as a predominantly health-based program, our experience would suggest that important contributions and the needed cooperation from associates in the fields of education and social service will not be effected.

I want to move now to a point concerning Section 102 of S. 2910, specifically Item #6 pertaining to the use of grant funds for providing training. The proposed bill excludes support for institutional training or training and assistance provided by consultants. It appears to draw from the expertise of personnel associated with

existing programs. In identifying core services for a comprehensive school-age parent program you will observe that NACSAP differentiated between the needs of clients and those who are working directly with young people. In-service training has been one type of technical assistance which NACSAP has offered in its program over the past few years sometimes in specialized training courses and at other times through national conferences or individual consultant services. For example, to date, NACSAP has helped to develop and conduct state and regional in-service training courses in Oregon, Washington, Maryland, Louisiana, Texas, West Virginia, Illinois, Colorado, and Pennsylvania. In the case of Colorado and Pennsylvania, our representatives were participating as staff in regional programs developed by the Department of Health, Education, and Welfare. The course content was generally designed to help professionals and others who are working with sexually-active youth and young parents reach an understanding about their own values and perceptions of self, sexuality, and parenting so that they can relate to young people and their families. In some instances the courses offered have been accredited by higher education institutions (e.g., University of Oregon, University of Texas/Galveston, and Eastern Washington State College at Cheney). Instructors in these courses have, in some cases, been independent consultants selected on the basis of their relevant expertise. On the basis of the experience with these training programs, NACSAP would urge that consideration be given to the incorporation of a waiver clause in Item 6 so as to allow the use of funds for training by institutions and/or consultants pending the review of training methodology and faculty.

Item #6-E of Section 102 (Uses of Grants) imposes another restriction limiting any grantee from using in excess of 50% of its grant for services. Though a waiver is allowed, on the basis of the case made earlier about the lack of services in several communities, especially in suburban and rural areas, NACSAP urges that this restriction be revised to permit a grantee to use up to 75% of a grant for direct services.

NACSAP would make two recommendations about Section 104 of S. 2910 (Requirements for Grant Approval) which would perhaps be able to measurably strengthen the legislation. First of all, a maintenance of effort clause needs to be added. In effect, this would be an insurance premium to guard against the possible redirection or withdrawal of state, local, and/or private funds previously generated to meet the needs of this population. This recommendation is made on the basis of a fundamental understanding and appreciation for the sensitive nature of adolescent parent programs and in recognition of the fact that in the context of other human service concerns, this is yet a relatively low priority in most communities.

The second consideration is with reference to Item #6 in Section 104. As written, this Item requires grantees to describe how adolescents needing services other than those provided directly by the grantee will be identified and how access and referral to those services will be achieved. Included in the services described as "other" is infant, day and drop-in care services for adolescent parents". Infant day care cannot be viewed as a luxury service for adolescent parents. It has been proven among our constituents to be central to the concept of comprehensive services. Without it, the efforts to provide coordinated prenatal

services are destined to a short-term impact, an impact which, for all practical purposes, terminates at the point when the adolescent mother who has delivered her baby and has kept the child (approximately 90% of the over 600,000 adolescents who carry pregnancies to term are estimated to be keeping their babies rather than placing for adoption) attempts to return to school and finds there is no one to care for the baby when she is in school. As a central element in the core services program developmental infant day care is difficult and costly to provide. However, some states, e.g., California, and local communities, some of which you will hear about in testimony from service providers who are here today, can demonstrate that this is not an impossible resource to provide.

Title II of S. 2910 (Improving Coordination of Federal and State Programs) notes that the Secretary of DHEW will set aside up to 1% of the funds in this program for evaluation. From NACSAP's perspective this would appear to be an extremely limited allocation for an important aspect of comprehensive programs. The knowledge base concerning these programs is limited and predicated on very few intervention programs. We would urge that consideration be given to the use of a minimum of 3% and a maximum of 5% of the funds for evaluation. Further, in the regulations of the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978, a definition of the nature of the evaluation strategy should be provided with appropriate means of adaptation to health, education, and/or social service-based approaches.

There are several references to technical assistance in S. 2910 which NACSAP believes to be a pivotal point in terms of the poten-

tial for success of the program in general and specifically in terms of the outcomes for individual grantees. Technical assistance plans should be developed for use by federal, state, and local agencies that are working in this field. At a minimum the technical assistance should make available to interested persons guidelines for needs assessment at state and local levels; recommended procedures for developing and/or linking core services; considerations for shaping research and evaluation techniques; and, suggested formats for documenting efforts on short and long-term bases. In the work that NACSAP has been involved in in nearly 40 states over the last several years and through the network of programs with which we are associated, this is an area to which we hope we could make a meaningful contribution.

In summary I would like to emphasize once again our general support for S. 2910. I would further emphasize and underscore, however, the need to strengthen this measure through whatever means available so that a new program, were it to get underway, would not detract from or encumber the steps which have already been taken to prevent adolescent pregnancies or treat the needs of families involved in such a circumstance. This bill places considerable responsibility in the hands of those who would develop the regulations and subsequently chart the administrative course. Because of the complexity of this effort, which I hope has been charscterized in my testimony, NACSAP would suggest that DHEW be required to develop regulations and conduct this program in concert with an Advisory Committee comprised of persons with expertise in the provision of services; research and evaluation; and/or policymaking with respect to this popu-

lation. Without such a Committee, a Committee that could conceivably relate to the other elements of the Teenage Pregnancy Initiative, it will be extremely difficult to strike the necessary balance to satisfy recognized needs for effective primary prevention and treatment programs.

It is doubtful that any of the witnesses appearing before you today speaks only for young people who are at risk of pregnancy or only for those who are pregnant or only for those who are young parents. I believe we are here in the interest of all of those constituents and their families. Nonetheless, it would appear that S. 2910 has its greatest potential as a beginning effort to address the needs of pregnant adolescents and young parents. NACSAP looks forward to working with Congress and the Administration in promoting a comprehensive effort which results in an effective, compassionate, and much needed program which cannot conscionably be delayed. Thank you for the opportunity to testify.

Attachments: National Directory of Services for School-Age Parents
1977 NACSAP National Conference Program
Membership Brochure

new FUTURES SCHOOL

A COMPREHENSIVE PROGRAM
FOR SCHOOL-AGE PARENTS

APS
ALBUQUERQUE
PUBLIC
SCHOOLS

110 Broadway Blvd., NE
Albuquerque, New Mexico 87102
242-0293 243-1709

NEW FUTURES SCHOOL

New Futures School is a comprehensive program for school-age parents. It offers educational, health and social services to young women and their families at a most crucial time in their lives.

The program goals are:

1. To instill a healthy self-concept.
2. To help solve personal problems that may lead to or result from pregnancy.
3. To aid in the development of a satisfactory relationship with family and society.
4. To prepare girls for motherhood.
5. To assure continuation of the girl's educational program.
6. To ensure that girls receive early and continued prenatal and postnatal care.

Techniques utilized to accomplish these goals include individual and group counseling, educational classes, individual and group health counseling and instruction, and laboratory experience with infants in the program nursery. These techniques operate within an atmosphere of love and concern for each individual. It is this atmosphere of caring which is the key feature of New Futures School.

The New Futures School is a project of the Albuquerque Public Schools, with support from various community, state and federal agencies, and from concerned individuals. It is housed in an Albuquerque Public Schools facility formerly occupied by Albuquerque High School. New Futures, Inc., a private, non-profit agency, funds some services of New Futures School and serves in an advisory capacity to the program.

Program enrollment is open, free-of-charge, to any pregnant adolescent. Entrance into the program is relatively simple, and may be accomplished by a visit to the program office or by a phone call to request a contact by a N.F.S. staff member.

The New Futures School program has proved to be highly successful. It has had a strong impact on the lives of many young women. Its success is evidenced by personal evaluations from program participants, observable behavior changes, measurable statistics such as the low number of repeat pregnancies, the high rate of return to school and progress toward high school graduation and beyond, the low drop-out rate within the school itself, and by community acceptance by the general public and professionals in agencies which serve troubled adolescents.

A frequently repeated comment in student evaluations most clearly expresses the philosophy of this program..."*At New Futures School I found people who cared.*"

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WHY COMPREHENSIVE SERVICES TO SCHOOL-AGE PARENTS ARE IMPORTANT

Pregnant adolescents have special needs which we believe can best be met within a special school setting.

Pregnancy is the largest known cause of drop-outs among secondary school girls. Society must recognize that if proper intervention is not provided in the lives of teenage parents, the future is not bright for either mother or child. Many girls who become pregnant out-of-wedlock have led emotionally deprived lives, often in families where home life is erratic and insecure. Many have not been successful in school. Their self-image is often low, and is forced lower by the disapproved pregnancy. The problem of damaged self-image exists even in the cases of girls to whom the above descriptions do not apply. If such an individual withdraws from society for six to nine months, and/or finds herself with yet another situation with which she cannot cope, she has little to do but engage in self-recrimination, self-pity, bitterness and defiance. Such withdrawal from the society of her peers and the adult world prevents her from working through her personal problems and leaves her with psychological scars which may last throughout her lifetime and affect her relationship with her baby. If she can learn to handle this crisis, she will be much better prepared to handle her problems in later years.

The girl who married as a result of her pregnancy faces special problems. An adolescent who is attempting to learn the roles of wife, mother and housewife all at the same time needs much support. The financial demands on the young couple are great, and are compounded by the fact that the married girl cannot receive welfare aid as can the single girl, and that the young father is frequently a school drop-out with few skills. The feelings of the young couple's parents frequently place an additional strain upon the marriage. Statistics indicate that well over 50% of such marriages will end in divorce.

In the case of many school-age parents, sexual acting-out is not the only symptom of problem behavior. Some are drug experimenters or have been implicated in law-breaking or truancy.

Thought must also be given to the babies of school-age parents. These young parents are generally ill-equipped educationally, emotionally, and financially to give high-standard care to their infants. Eighty-five to ninety percent of N.F.S. students have made the decision to keep their babies before they enroll in N.F.S. Those who release for adoption may marry and have children within a few years. The necessity to prepare young parents for parenthood is imperative. The student comment which is all-too-frequently made, *"How can I learn to love my baby when I don't love myself?"*, reflects the need for comprehensive services in order to produce any long-lasting effects.

Blanket statements are dangerous with regard to any group in society. Many school-age parents come from fine families and good neighborhoods. Many are intelligent, religiously-oriented and concerned. Few could be called promiscuous. But all have needs for special services to enable them to get through this difficult period and to face the future with confidence, competence, and joy.

Four general areas of service are essential in meeting the needs of pregnant adolescents: education, health, social services, and infant care. A fifth important area of service is that of work with the young fathers and family members of the teenage mother. Services in each area must be correlated and interrelated with services in the other areas in order to be really helpful to the service recipient. New Futures School is a genuinely comprehensive program, unique in the southwest, offering services in all these areas. A broad description of each of the service areas is contained in later pages of this booklet.

Implicit within the comprehensive services of New Futures School is the understanding that each N.F.S. participant develops positive understandings and concepts regarding family planning. The teaching of birth control techniques cannot be effective with pregnant adolescents without the concurrent development of the girl's perception of herself as a person and of her relationship to her expected child as an individual with needs and demands, and of her relationship to the world around her and the role she can play in it.

Without involvement in the services of a comprehensive program, there is great possibility that the pregnant adolescent will become the school drop-out, the delinquent or criminal, the unemployable, the welfare recipient, the physical or mental risk. There is every possibility that she or her child will become dependent on society through the welfare system, the judicial system, or ill health. Intervention by comprehensive services is essential and, in the long run, relatively inexpensive.

CLIENTELE

There are only three eligibility criteria for entrance into New Futures School: 1) doctor's certification of pregnancy; 2) 13-19 years of age; 3) not yet a high school graduate. In addition, it is understood that a girl may not participate in New Futures School classes a second time if she was in N.F.S. during her first pregnancy. (She may receive health and counseling services.) A student who meets the above criteria for entrance into the program may, of course, continue to be served after some or all of the entrance conditions no longer prevail.

The New Futures School enrollment always includes representatives of the four cultural-ethnic groups of New Mexico...Spanish-surnamed, Anglo, Black and Indian. Each year every high school in Albuquerque and a number of junior high schools and out-of-town schools are represented in the student body. Both the staff and the girls themselves feel that this mixture is one of the strengths of the New Futures School program. The meeting ground thus provided is all too rare in the Albuquerque community.

New Futures School services are available to married girls as well as single girls. National statistics on the success of teenage marriages predict a divorce rate of 50% or higher. The married student has equal needs for the health and counseling services and the general and parenting education classes. Approximately 40% of N.F.S. students are married.

While a majority of N.F.S. students plan to keep their babies, there is a sizeable group of girls who plan to release the infant for adoption or who are undecided regarding their plans for the baby. Every effort is made through staff work and individual curriculum adjustment to make these girls feel that their enrollment in N.F.S. is as valuable for them as it is for any other girl. Feedback from N.F.S. girls who have released for adoption indicates that they have found New Futures to be very meaningful and helpful.

New Futures School services, particularly counseling services, are offered to members of the extended families of the N.F.S. student participants. A "Mothers' Group" (which has included aunts, older sisters, grandmothers and neighbors as well as mothers) meets weekly. Evening groups or special activities are held to involve husbands, boyfriends, or the entire family in health instruction and/or counseling-oriented activities. Counseling and out-reach social services are also available to the young fathers.

A girl may enter N.F.S. at any time during her pregnancy. She may be self-referred or referred by a community agency or individual. Once enrolled, a student may remain in the program after her pregnancy is completed until such time as the girl, her doctor and the N.F.S. staff feel that she no longer needs the regular support services of N.F.S. The time of leaving active N.F.S. enrollment usually coincides with the end of a grading period. The average length of stay in N.F.S. is 5 months, but this may vary greatly in individual cases.

Students from outside the Albuquerque metropolitan area who desire to attend N.F.S. may be aided by N.F.S. counselors to find housing in Albuquerque. Housing possibilities include Chaparral Home and Birthright share homes.

There is no charge for any New Futures School service.

ENTRANCE PROCEDURES

A girl may enter New Futures School at any time. It is preferable that the change from public school be made at the beginning of a grading period -- the quarter or semester -- but the transition can be effected at any time the girl, her school or her doctor, feel that it should be made. A girl who has been out of school can also enter N.F.S. at any time.

A girl who wishes to attend New Futures School should contact the N.F.S. office at 110 Broadway Boulevard, N.E. -- 243-0293 or 243-1709. If she desires, a N.F.S. counselor will then visit with her in her home or at her school to give her more information about the program. She may, if she desires, come to N.F.S. to enroll without prior contact or interview with us. With the first interview, the girl will be given a doctor's permission form which her doctor must sign, certifying that she is pregnant and that she is physically able to attend N.F.S. Every effort is made to minimize red tape and to effect entrance as easily and rapidly as possible.

In addition to the girls who contact the program on their own, students may be referred to the program by staff members of community agencies, by medical personnel, or by school personnel. An individual who wishes to refer a girl to N.F.S. may call the N.F.S. office with information about the girl. A N.F.S. counselor will make a follow-up contact.

PROGRAM STRUCTURE

A New Futures School program recipient may participate in as many of the service activities as she desires.

In the education service area, traditional, rather than block or flexible, scheduling is used to minimize the effects of absenteeism. The standard routine makes it easier for students returning from absences or new students just entering the program to fit smoothly into the educational program with a minimum loss of continuity. Six class periods are offered each day. All classes meet five days weekly. Albuquerque Public School vacation and holiday schedules are followed. Students may take from one to six classes, depending on their interest and needs. Occasionally, a class may be offered through independent study to meet a particular need. A short summer school session is held during the month of June.

The Infant Observation Center, a small nursery for infants of girls in the program, is a major component of the program structure. It serves as a babysitting facility, a training laboratory for all New Futures School students, and as an observation facility to enable the staff to aid girls who may be having problems caring for their babies. It is open during school hours only.

Health information services are offered both in group instruction and individual counseling. The Health Director and Health Assistant are available daily to consult with students individually, to make home visits, and to teach groups.

Nutrition is a major part of the N.F.S. health program. As a part of the nutrition program of the school, a hot lunch and supplementary snacks are served daily, free-of-charge, to program participants. The meal and snacks are planned by the N.F.S. nutritionist to meet the special nutritional needs of pregnant teenagers, while keeping in mind the weight control problems which many of the girls have. Menu planning is coordinated with results of individual diet analyses of N.F.S. clients.

Counseling services are available daily. A student may receive individual counseling as frequently as she desires. Each student is involved in group counseling once a week. Girls who are considering releasing their baby for adoption participate in an additional counseling group.

A girl may receive counseling, referral or health services from New Futures School without taking classes. Many former N.F.S. students avail themselves of this opportunity. Other follow-up services are offered on a need basis.

Services are also available to members of the extended families of program enrollees and to the young man with whom the girl is involved. Various techniques, some regularly scheduled and some of a special event nature, are utilized to involve family members, singly or in groups, in activities which help them to understand and to contribute to the development of the girl.

Many New Futures School students use city buses for transportation to and from the program. Bus tokens are provided by N.F.S. to the girls for this purpose. Students who do not live near bus lines may be referred to the volunteer transportation services of Birthright, or arrangements can be made for APS bus transportation.

Every effort is made to provide in New Futures School an environment in which each student will mature in self-understanding and responsibility, and in the ability to make decisions for herself. Many girls must make very crucial decisions during the time they are enrolled in N.F.S. Decisions such as keeping the baby or releasing it for adoption, marrying or remaining single, continuing her education or entering the job market, and others must be faced by these young women. Continuous efforts are made to provide requisite learnings and an atmosphere free from pressure in which such decisions can be made.

EDUCATIONAL SERVICES

The teaching philosophy and techniques in New Futures School are geared to the needs of the girls in the program. Students are involved in the planning of the curriculum and in the evaluation of its effectiveness. Each teacher is free to innovate teaching methods and course content within the framework of the school's philosophy and objectives. Classes are small -- no more than twenty per class -- which allows for individualization of instruction and maximum involvement by each student. All teaching techniques are success-oriented, and are often individually paced.

Classes are offered at the 7th, 8th, 9th, 10th, 11th, and 12th grade levels. A student may carry from one to six subjects. A normal class load is five subjects, or 2½ credits, the same as the normal load in the public schools.

Past records indicate that most students achieve at a higher level in N.F.S. classes than they did in their previous schools.

While one of the school goals is to encourage and allow girls to progress toward a high school diploma, it is also recognized that this is not practical or preferable in some girls' situations. Such girls are encouraged to prepare for the G.E.D. test, a high school equivalency test, and their curriculum is adjusted accordingly.

Classes are offered in the following subject areas:

FAMILY LIVING

Family Living, a semester course, is the only class required of all N.F.S. students.

The course centers on the various aspects of being a pregnant teenager: her anatomy, physiology, and care through the maternity cycle; the decisions she is and will be making. Emphasis is placed on the understanding of herself and on family relationships as she goes through this new experience.

An integral part of this course is a discussion of human sexuality with emphasis on sexual decision-making in addition to family planning and methods of birth control. She will be helped to examine female and parental roles as influenced by her cultural heritage, family, and friends. Growing towards emotional maturity and better family relationships are primary goals of Family Living.

The Health Director and Family Living Specialist team-teach this class, with the counselors also being involved. Many audio-visual aids and guest speakers are utilized in teaching Family Living. Field trips to a hospital maternity area and to a Planned Parenthood office are included.

CHILD DEVELOPMENT

Child Development offers each student laboratory experience in infant care, with accompanying instruction. Class members participate in the care, in the nursery, of infants of N.F.S. students. After appropriate instruction and reading, each girl must successfully complete a checklist of infant care experiences, such as bathing, changing, preparing formula, clothes washing, feeding, making safe toys, and maintaining nursery hygiene.

Theory of child development is also included in this class. Students learn realistic expectations for children, parenting attitudes, and the emotional needs of children. A unit on child abuse is included.

COMMUNICATIONS

The purpose of this class is to lead to greater self-understanding and self-development through the media of literature and creative writing. A variety of reading materials, including much modern literature as well as classic writing, is read and analyzed. Efforts are made through group discussion to help girls relate the readings to their personal situations and to their goals for the future. The creative writing focuses on the same goals.

CHILDREN'S LITERATURE

A class in children's literature reinforces parenting education concepts taught in other courses. Students learn the emotional needs of children, as well as the importance of stimulation through oral and written stories, by reading, analyzing, and creating children's literature.

ENGLISH-READING IMPROVEMENT

The strengthening of reading skills is the major part of this class. Specialized reading materials are utilized. Assignments are usually individualized according to the interest and needs of each girl. The basics of English usage are also included. Some creative writing and self expression is done. Girls often improve several grade levels in reading while in this class.

CREATIVE HOMEMAKING

In Creative Homemaking we do sewing projects that are of interest to and within the abilities of the students. This would include such things as layettes, maternity clothes, baby blankets, and decorative items such as pillows or cushions for the home. Also fabric craft activities, such as macrame, crayon batik, tie dye, embroidery, and crocheting, can be done in this class.

COOKING FOR FUN

In Cooking for Fun the student is made aware of the nutritional needs of the body during pregnancy and how a good diet brings about better health for the student and her child. The student will become a better consumer through the use of good buying habits, such as planning and anticipating the family needs and doing comparison shopping. The student will learn to plan menus (built around the basic four food groups) that best suit her family's needs and income. The student will learn and use the techniques of cookery through actual experiences in the kitchen. Crafts, such as bread dough crafts, will also be incorporated into this class.

MATHEMATICS

A number of courses are offered in the mathematics area, with each pupil working at her own rate and keeping a notebook reflecting her progress. The teacher serves as a resource person in this process.

PHYSICAL EDUCATION

Adaptive P.E., specially tailored to meet the needs of girls in both pre-natal and post-partal stages, is a popular elective. The course is designed to meet the girls' physical, emotional and social needs. Opportunities for leadership development are provided. Each class period includes a beginning exercise period. Following this, the girls participate in a group activity such as international folk dancing, tennis, badminton, volleyball, table tennis, swimming, bowling or platform tennis. Through participation in such an activity, the girls learn the pleasure of wholesome group activity and are provided an opportunity to forget other problems while enjoying pleasant recreation. Emphasis is also placed upon developing skills and interest in healthy leisure time activities.

SOCIAL STUDIES

The Social Studies program is designed to provide some of the cultural background necessary for intelligent and responsible living.

A course entitled "Your Community -- Then and Now" has two major focuses. Students learn about their community, its resources, and how they may utilize these resources. The responsibilities of citizenship and the means of participating in community processes are a second focus. The historical development of the community is studied as a method toward understanding the present.

An APS required course in U.S. History is also included in the curriculum.

TYPING, SHORTHAND, BOOKKEEPING

Both beginning and advanced levels of typing are offered. Students gain experience on manual and electric typewriters. Classroom activities for advanced students include letter-writing, manuscript-typing and other kinds of office practice. Practical experience is gained by having students type for teachers and perform office duties needed by N.F.S. Field trips and guest speakers are additional classroom activities which help prepare the student for entering the business world.

Individual instruction in all levels of Shorthand and Bookkeeping is also available. Students may receive some instruction in cashiering and filing.

BIOLOGY

The biology curriculum is a general study of plants and animals, with the major emphasis of the class on the human body. The class activities include lectures, labs, field trips, and the use of guest speakers.

STUDENT COUNCIL

The Student Council is an integral part of the school curriculum. Through the council the girls accept and carry out responsibility for many aspects of the over-all school program. They plan social events and other projects for the group. The student council carries a major responsibility for developing a close interrelationship among the girls. Through their council activities the girls grow in acceptance of responsibility for themselves and others. They acquire self-confidence as they accept leadership roles, tackle problems, and see the positive results of their actions. The student council is a major factor in the self-development of the participants in New Futures School.

COORDINATION

Through weekly staff meetings, a continuing effort is made to interrelate the focuses of attention in the various phases of the educational program. Assembly programs and field trips which relate to areas currently under study are held frequently.

Close contact is maintained with each student's home school. Health and school records and other types of information are exchanged. School counselors are consulted regarding a student's program of classes.

New Futures School students remain on the rolls of their regular Albuquerque high schools while they attend New Futures. If a girl completes her high school graduation requirements while enrolled in N.F.S., she receives her diploma from her home high school. A N.F.S. graduation ceremony, planned by the graduating seniors, is held each May. A girl may receive her official APS diploma in this ceremony or she may receive it in the graduation ceremony of her own school.

HEALTH SERVICES

New Futures School has the services of a Health Director, a Health Assistant and a Family Living Specialist. The Health Director is a registered nurse who coordinates the several types of health services. The Health Assistant is an L.P.N. The Family Living Specialist is an R.N. with specialties in the pre and post-natal needs of pregnant adolescents, human sexuality, family planning, and parenting education. The nurses participate in team-teaching the Family Living classes. The health staff also serve as health resources for babies in the Infant Observation Center.

The Health Director or her assistant takes a health history on each girl as she enters N.F.S. This information is supplemented with information from the school nurse of the girl's home school and from her physician. The health staff keep a record of each girl's medical appointments. They check to see that the appointments are kept and that communications between doctor and girl are understood.

Each girl's weight is checked regularly and she is counseled regarding weight problems. Phone calls made to absent girls allow the nurse to offer health advice when it is appropriate. Nurses are available daily to consult individually with girls as they request such conferences. They handle such problems as are within their capabilities and alert the girl and her doctor regarding those problems which require the physician's help. Nearly all the girls have fears regarding the emotional and physical aspects of pregnancy. The health staff plays a key role in alleviating these fears.

Following the delivery of the baby, an N.F.S. nurse makes a home visit. The purpose of the visit is to evaluate the home environment and the girl's post-natal adjustment. The nurse ascertains if any complications have arisen either with the girl or the baby and makes suggestions to alleviate conditions which she feels are inadequate. Referrals are made to other health agencies if the need exists. The girl's plans for return to school are discussed with her, and a tentative date is set.

Birth control information is an important part of the health program. A unit on the various aspects of family planning is offered in the Family Living class. This unit includes many aspects of human sexuality in addition to birth control methods and the rationale of family planning. A tour of the Planned Parenthood facilities follows. As mentioned earlier in this booklet, a great many of the components of the program of New Futures School contribute to the acceptance and the understanding of family planning concepts by the girls and their families and to the maturity required to use them.

The nurse, while making her post-partum visit, discusses the girl's decision regarding her use of birth control measures and reminds her to make definite plans with her doctor at her six weeks examination. During the girl's last week in New Futures School, the nurse makes a final check with her regarding her health and that of the baby, and again verifies that she has been provided with the birth control method of her choice.

New Futures School is fortunate to have a close working relationship with the Maternity and Infant Care Project, a federally sponsored program serving high risk mothers and infants. An M & I clinic is held in the New Futures School building once a week. A majority of the girls use the medical facilities of this project. This enables the health staff to be more certain that each girl is seeing a doctor regularly, lowers the school absentee rate, and allows for close coordination between the girl's medical care-givers and N.F.S. health staff. A well-baby clinic is held at N.F.S. once a month, staffed by the M & I pediatrician.

When a girl returns to her home school, a summary of her health status is sent to the nurse at the home school to facilitate better communication and understanding of her health needs.

SOCIAL SERVICES

Through the N.F.S. social services, each girl makes real progress in working through the problems which led to or are caused by her pregnancy.

SUPPORT

New Futures School provides each girl with a supportive atmosphere in which to work out her problems. One factor is the group support which the student body gives to each member. Loneliness and despair are ameliorated by the concern and empathy which girls give to each other. Equally important is the attention and concern given to each student by each of her teachers. The student is not just a name in a classroom, which many of them have been in their home schools, but an individual with unique abilities and needs. The teacher works with her on this level. The students also come to realize that behind the adults who are in direct contact with them are a large number of other adults who also believe in them and contribute many hours toward providing opportunities for them.

COUNSELING

Special counseling services are available to the girls through N.F.S. Four professionally trained counselors are members of the N.F.S. counseling staff.

A counselor conducts the intake interview with each new student. The groundwork for counseling is laid through this contact. Regularly scheduled individual counseling, as well as joint counseling with the girl and her mother, father, husband, or boyfriend, is offered to the girl. While counseling is not required, experience indicates that almost all students do seek it on a voluntary basis. Crisis intervention counseling is available to the girls at any time. The counseling philosophy is to assist and enable the girl to work through her problems, sort out her alternatives, and make her own decisions. The counselor carefully avoids giving the girl "advice".

Group counseling is also a part of the counseling program. Each girl participates in a group once a week. Groups are also scheduled for mothers, husbands or boyfriends, and for those girls who are considering releasing the baby for adoption.

Referrals for counseling, when appropriate, may be made to the social service workers of the Maternity and Infant Care Project, to adoption workers of the H.S.S.D. Social Service Agency, and Chaparral Adoption Services, to the Albuquerque Public Schools psychologists, to the Bernalillo County Mental Health Clinic, and to the Child Guidance Center.

Referrals are frequently made to other social agencies and community resources for girls who are in need of specialized services. These types of referrals include those for legal assistance, food stamps, financial assistance, housing, vocational training, and job placement. A counselor often accompanies the girl in making the initial contact to aid her in expressing her needs adequately.

The counseling services include efforts to involve members of the student's family in counseling activities. This involvement is regarded as essential for two reasons: (1) the relationship the girl has with these individuals during her pregnancy is critical in determining how she views herself and her baby; and (2) she will in most cases maintain close ties to these individuals after she leaves the program, with the feedback she gets from them continuing to be of prime importance in the maintaining of the positive attitudes developed here.

The services of a male counselor are available to the putative father.

Counseling services are available to New Futures School students after they cease to be active program enrollees. Many girls avail themselves of this opportunity. A group of former students meets with N.F.S. counselors on a weekly basis. Other former students seek individual counseling.

INFANT CARE FACILITY

An infant care facility is available to New Futures School students. The nursery is used by girls who have no babysitter available to them, by girls who are breast-feeding their babies, and in some cases, by girls who are having problems caring for their infants. Each girl who places her baby in the nursery has accompanying responsibilities. She must provide all information required for the baby's care (schedule, medicinal requirements, etc.) and the day's supply of food and clothing, and must work in the nursery as an assistant one hour daily.

A second major function of the infant care facility is that of a learning laboratory. Through experiences in Child Development class, a baby becomes a real human being with needs and demands which must be met. Fears in handling infants are overcome. Infants' health, nutrition, and safety needs, as well as emotional needs, are emphasized.

No-smoking and other health rules are strictly enforced in the nursery. A nurse makes a daily check on the infants. Entrance into the nursery is limited to mothers of the infants and girls assigned to be aides hourly.

VOCATIONAL ORIENTATION

Attempts are made in several ways to orient New Futures School students to the world of work. We believe that a majority of our students will have to hold a job within a few years after they leave N.F.S. The three primary purposes of the vocational orientation program are: (1) goal-setting to make the girl believe that her pregnancy need not limit her vocational goals and to broaden her horizons regarding the roles open to women in today's society; (2) preparing the girl with some specific job-oriented skills -- typing, shorthand, bookkeeping, child care, and food preparation -- as well as basic mathematics and English-usage skills; and (3) job or training referral at the time of leaving New Futures School.

The first goal is of prime importance with pregnant adolescents. Many state on the intake interview, *"Well, I WAS going to study to become a _____."* This sense of defeat must be overcome before the girl has a chance to become economically independent. Girls who come from welfare-dependent or poverty-level families need encouragement to raise the level of their aspirations. All phases of the New Futures School program attempt to work toward this goal. It is a particular focus of the Communications class, the Social Studies program and the counseling program. All-school activities such as Career Day contribute also. An intangible, yet important, factor is the example of the staff -- most of whom are very involved with raising their families in addition to their professional activities.

The second goal -- that of teaching job-oriented skills -- is accomplished primarily by the business-vocational teacher. Business classes are individualized, with lessons prepared to carry each girl forward from her present level of achievement at an individual pace. Manual and electric typewriters, and some business machines, are available. Varying levels of shorthand and bookkeeping are taught. Some girls will also use job skills acquired in Child Development classes as our society needs more trained workers in Day Care programs. Cafeteria skills classes also provide training skills. (Basic job-required skills are regularly stressed in mathematics and English classes.)

Girls often go directly into a job after leaving N.F.S. Some are summer jobs, while others are full-time jobs for high school graduates or girls who choose to take the G.E.D. test in lieu of high school graduation. Others need part-time jobs and need to find a school program which will allow them to both work and complete their high school education. Some girls want to further their skill training through the Albuquerque Technical-Vocational Institute, or a community training program. The New Futures School counselors assist N.F.S. students in making contacts for job or training possibilities and in finding flexible school schedules which allow them to work. The business-vocational teacher plays a role in job and training referral also. The putative father may get help in seeking job training or employment from the N.F.S. counselors.

STAFFING

Each New Futures School staff member is a specialist in his or her field. Potential staff members are carefully screened for both professional competence and the ability to inter-relate in a positive way with the troubled adolescent. Each staff member realizes that the emotional support he or she gives to the girls is of prime importance to the success the girl has in the program. Professional backgrounds of staff members include counseling, social work, nursing, administration, teaching, and the ministry. All teaching personnel are certified in the fields in which they are teaching. In order to achieve this specialization, many staff members are part-time. Over fifty percent of the professional staff have masters degrees or are working toward this degree. Para-professional staff members are also utilized as part of the staff team.

Staffing is cross-cultural, with efforts made to include representatives of the various communities from which the program participants come. It is necessary for some staff members to be bi-lingual.

Study of comprehensive programs in other states led N.P.S. staff and board to a realization of the danger of separating the staff into "educational", "health" and "counseling or social-work" components. Such separation can easily lead to a splintering of goals and occasional working at cross-purposes. Each staff member of New Futures School -- nurse, counselor, teacher, secretary, nursery-aide -- is committed to the multi-faceted development of each girl. Staff training includes strong emphasis upon the need for working together to achieve a common goal. Weekly sharing meetings between health and counseling staff members are useful in this area. Weekly all-staff meetings promote team planning and coordination.

Volunteers are used in a variety of ways to enrich our program. Guest speakers are used extensively in several classes to share their expertise and perceptions with the students. Volunteers may assist with meal preparation, driving for field trips, and interior decoration as well.

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FOLLOW-UP

Follow-up services are an important part of New Futures School. While every effort is made to prepare the girl to return to public school, the adjustment is necessarily a difficult one. The adjustments to new roles within her family are just as difficult. To meet former N.F.S. students' continuing needs, follow-up counseling and health services are offered. In addition, follow-up information must be used to determine how the program can better help students to adjust to their new situations and responsibilities.

Formal evaluation and follow-up activities are planned at regular intervals. These activities involve responses by both the former participant in the program, and by those who are in a position to observe her; i.e., school counselors and teachers, school nurses, and N.F.S. staff members making follow-up contacts. Each girl fills out an evaluation sheet on N.F.S. once each semester.

Follow-up contacts are made with each girl during the summer after she leaves the program, and each summer thereafter. Items of particular concern are: number of repeat pregnancies, school grades, high school graduation, school drop-out rate, physical health of the mother, physical health of the baby, problems of family adjustment, adjustment to the role of mother -- or adjustment to her decision to give up the baby, successful marriage, emotional state, and post-graduate education or training. While some of these factors are intangibles, and therefore very difficult to measure, the girl's feelings about them are very real and very significant, as is the image she presents to those with whom she is in daily contact. Earlier follow-up contacts are made if the staff has particular concerns about the individual or her baby. During the school year, N.F.S. staff contact school personnel to inquire about girls who have returned to their schools.

Informal contacts are maintained with each girl after she leaves N.F.S. Girls are invited back twice a year to an informal party, to share their experiences and to renew their acquaintances with N.F.S. staff and with each other. Those girls who wish to bring their babies with them to this party are invited to do so. Many former New Futures students frequently call or come by the school to discuss problems or "just to talk". N.F.S. staff members may at this time make referrals to other agencies which may be able to meet the girl's needs. The main purpose of the informal follow-up activity is to let the girl know that her relationship with the supportive staff of the New Futures School can be a continuing one as long as she feels the need for it.

COMMUNITY SERVICES

New Futures School has been increasingly called upon to give services to groups beyond the N.F.S. school setting. N.F.S. staff are available as workshop leaders and speakers for staff training for groups interested in services to adolescents, human sexuality, family planning, and parenting education. Counselors and health staff from N.F.S. are frequently invited to make presentations on the problems of teenage pregnancy and related topics to school classes and young peoples groups. We are always happy to fill such requests. The N.F.S. student-made slide-tape presentation "I'm Not Bad, Just Pregnant," which portrays a number of very realistic viewpoints on teenage pregnancy, is available for use by groups upon request, for the cost of mailing. It has been used in public schools, university courses, and special programs for teenagers around the country.

New Futures School is also able to make available programs by staff, volunteers, and panels of former students, and conference packet materials for community groups and state, regional, and national-level conferences. Through these means, we hope to encourage both community support for existing teenage parent programs and the development of new programs in areas where services are inadequate.

CO-OPERATING AND SPONSORING AGENCIES

New Futures School, originally called the Pregnant Teen-Aid Program, was begun in January, 1970 by the Albuquerque Y.W.C.A., in co-operation with the Albuquerque Public Schools. The program was co-sponsored by the Y.W.C.A. and the Albuquerque Public Schools until July, 1976, when the Y.W.C.A. ceased its role.

A group of interested citizens have formed a non-profit organisation whose purpose is to be concerned with services to young parents. This organization, New Futures, Inc., serves in an advisory capacity to New Futures School and funds some services of N.F.S.

The continuing existence of New Futures School is a result of co-operation between a number of local, state, and national organizations and concerned individuals. Additional support, in terms of money, goods, or services, has come from the following groups and organizations:

Bernalillo County
Beta Sigma Phi - Beta Chapter
Chaparral Home and Adoption Services
Dairy Council of the Rio Grande
Episcopal Diocese of the Rio Grande
IBM Corporation
KAFB Officers Wives Club
Maternity & Infant Care Project
Model Cities
Neighborhood Youth Corps (Youth In-School Employment Project)
New Mexico Health & Social Services Department
New Mexico Department of Hospitals & Institutions
New Mexico School Lunch Program
National Foundation - March of Dimes - New Mexico Chapter
Opti-Mrs.
Planned Parenthood Association of Bernalillo County
St. John's Episcopal Cathedral
University of New Mexico
Vocational Education Division - State Department of Education
Young Men's Christian Association
Young Women's Christian Association

Some of the above agencies provided single grants, while others provide on-going financial or in-kind support. In addition, a number of individuals and associations have given sustaining contributions or have donated services.

Each individual is unique; it is therefore impossible to describe accurately the "Typical Pregnant Teenager". It is true, however, that studies have shown that many pregnant teenagers are shy, passive, withdrawn and non-verbal. Passive hostility to a world which has not met their emotional needs is often just below the surface. Many were poor students in school. They caused no problems in the school classroom because they were really not there -- they attended, often irregularly, in body only. This girl's home life was often erratic and insecure. For this individual, security is a boy friend, sex a form of expression -- and pregnancy is the undesired by-product.

National studies indicate that sixty percent of those who become pregnant under the age of 16 will have another child while still of school-age. In order to break the pattern, to prevent future pregnancies, the girl must become self-confident and involved. She must be given the tools with which to cope with her environment, and a depth of self-understanding which will enable her to use them. This is the goal of the Albuquerque New Futures School.

Helping families is ACCL concern

Preservation of the family in the midst of changes is one of the most important challenges we as a nation face, according to a statement prepared by ACCL for congressional hearings in preparation for a White House Conference on Families next year.

President Carter announced in January that the Conference on Families will convene on December 9-13, 1979. During his campaign Carter stressed the need for federal support of families. The conference is a result of a concurrent resolution in Congress.

ACCL's statement was submitted to the subcommittee on child and human development of the Senate Committee on Human Resources and to the subcommittee on select education of the House Committee on Education and Labor. Representatives of the administration and research, religious, ethnic, service and advocacy groups were invited "to assess the progress and direction of plans" for the conference.

ACCL's statement recognizes the family unit as the "primary social institution through which individuals are protected, nurtured and helped to reach their potential. The family provides sustenance and trains its members in the art of surviving; it provides our earliest group interactions, and it is the primary vehicle for transmitting our values and knowledge of culture from generation to generation."

Quoting from "To Empower People: The Role of Mediating Structures in Public Policy" by Peter L. Berger and Richard John Neuhaus (reviewed in the July 1977 issue of Update), the statement acknowledges the diversity of life styles of today's families and the scarcity of the fully extended multi-generational family of yesterday. But while the family is in crisis as it undergoes changes, there is little evidence that it is in decline.

"... it is noteworthy that the counter-culture, which is so critical of the so-called bourgeois family, uses the terminology of family for its new social constructions, as do radical feminists pledged to 'sisterhood,'" Berger and Neuhaus wrote. "For most Americans, the evidence is that involvement in the bourgeois family, however modified, will endure."

Acci Update
March, 1978
Vol. 4, Number 2

HELPING TEEN-AGERS

Alternatives stressed

A 24-page written statement and recommendations for teen-age services as an alternative to abortion were presented by ACCL President Marjory Mecklenburg at congressional hearings held on March 1 in Washington, D.C.

Mrs. Mecklenburg was invited, along with five other panelists, to speak for 15 minutes on her testimony before the select committee on population of the U.S. House of Representatives.

The committee held task force hearings on Fertility and Contraception in the United States from February 21-March 9. The general focus of the hearings was the adequacy of the nation's family planning practice and services.

During the second week of hearings testimony focused on the nature, extent and consequences of adolescent fertility. Mrs. Mecklenburg's testimony was prepared for the discussion of teen-centered programs such as sex education in the home, churches, schools, and other social and community institutions; family planning services for adolescents; and maternity and adoption services for teen-agers.

"American Citizens Concerned for Life has had a long-standing interest in pregnant women, children and the family," Mrs. Mecklenburg wrote. "Our overall purpose is to motivate individuals, and society, as a whole, to make decisions about the use of available resources based on the premise that each human being has great value and that individuals should have the opportunity to realize their full potential."

Marjory Mecklenburg

Mrs. Mecklenburg emphasized that "Because there is evidence that adequate services for pregnant adolescents can significantly improve the lives of these young mothers and their children, there is both practical and ethical justification for providing them and their children with the best possible care . . . the best possible care necessarily means comprehensive care. The needs of pregnant teen-agers are so diverse that a program directed

TEEN-AGERS
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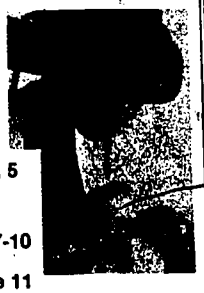
INSIDE UPDATE



Fetal experiments questioned

Seymour Siegal

Concern over what could be a secret world trade in fetal material has inspired criticism and demonstrations, denials, confusion, and as yet some unanswered questions.

An article in Win, a New York pacifist magazine (Dec. 1, 1977) said that Deputy Secretary-General of the United Nations Sean McBride announced in Tokyo recently that the Pentagon has imported 45,000 human fetuses from South Korea for the purpose of testing the neutron bomb on fresh human tissue. The article was also carried in Mother Jones magazine in the West.

"I gather that corpses are not fresh enough for this function," McBride said. He envisioned the fetal trade developing into an industry. The report was privately confirmed by a visiting executive of the South Korean Red Cross which administers 23 hospitals.

Subsequently four members of a group called Concerned Christian Citizens of Western Pennsylvania (an interdenominational prayer group) were arrested on Dec. 28 for protesting at Rockwell corporation headquarters in the U.S. Steel Building. The demonstrators charged that Rockwell personnel were participating in the neutron bomb testing on fetuses in a government plant in Colorado. After their hearing, the four were given 5-day suspended sentences.

Several Congressmen looked into the charges. Senator John Heinz of Pennsylvania received denials from the Defense Department as did Sen. Richard Schweiker (PA) who wrote to a protestor: "The Department of Defense told me they have never purchased any fetuses from any source for any purpose. The effects of radiation from a weapon such as the neutron bomb are well known, and would not require further research. If such research were needed, it could only be done on live test animals, not dead fetuses. Finally, Rockwell International is not involved in the neutron bomb project."

Also looking into the matter and meeting with denials from the Defense Department were Sen. Mark Hatfield (OR) and Rep. Michael Blouin (IA).

Earlier the Village Voice magazine (Mar. 21, 1977) described women who undergo abortions as possible unwilling participants in little-known U.S. military experiments.

The article described the process of fetal preparation from the cutting away by the doctor of identifiable parts of the freshly aborted fetus' body to the packing in ice to the chemical processing of chunks of fetal material into a final product — free-flowing human cells — sold to drug companies, research hospitals, and agencies of the U.S. government.

Village Voice also suggests that some doctors may be encouraging abortions on women well beyond the first trimester when "parts of the embryo are notably developed and thus infinitely more valuable for medical researchers.

Last year the Washington Post revealed that the pathology department of the District of Columbia General Hospital took in more than $68,000 since 1966 from the sale of aborted fetuses. It was noted that most of the profit of fetal sales went to administrators of the pathology department.

What principles of morality are involved in these events and discussions?

Rabbi Seymour Siegel, professor of ethics at Jewish Theological Seminary, has recently gave examples of three kinds of fetal experiments which would not be moral if a "bias for life" principle is accepted. That principle, he said, is the foundation of the Judaic-Christian world view.

Those that: give a drug to a pregnant mother before an abortion to see whether it will reach the fetus and then test fetal tissue after the fetus is removed; are carried on at the time of abortions before the fetus is removed; are conducted on a fetus after it has been removed but still shows signs of heart beat or brain activity. These should be prohibited, Rabbi Siegel believes.

Even if an abortion is planned and found acceptable by the persons involved, experiments that would harm the fetus are not permissible. In line with the philosophy that "you don't harm life, even though it has been sentenced to die, he explained, and only research that would be of therapeutic benefit to live fetuses would be permissible. Rabbi Siegel gave the keynote address at the third public forum on bio-medical ethics sponsored by the Minnesota Interreligious Committee for Bio-Medical Ethics on Nov. 3, 1977.

A life & death issue

This excerpt from "Abortion: Reflections on a Protracted Debate," by Ian Hunter (The Human Life Review, Vol. III, No. 4) is published with the permission of The Human Life Foundation, Inc., 150 East 35th St., New York City, 10016. Ian Hunter is an associate professor of law at the University of Western Ontario in London, Canada.

What criteria determine that one person's life is worth living, another's not? Is it vocational success, or a spring walk in the woods; is it running for political office, or an evening's sunset; is it earning, in the competitive marketplace, the respect of one's peers, or enjoying, as one's birthright, the love of one's parents?

It is not just the criteria to be applied that concern me but who is to decide them. Who has the training, the experience, the wisdom or the mandate to decide?

A court of Solomons and a legislature of philosopher kings would probably decline jurisdiction. Yet too many contemporary "quality of life" advocates show little reticence in deciding explicitly what are the criteria that make life worthwhile — is it by coincidence that lives which would meet their criteria bear a striking resemblance to their own?

There is a smug arrogance about this position which is disconcerting. Every time and generation, I suppose, implicitly believes in its own infallibility. Yet history teaches that each generation but sees through the glass of truth darkly, and that man's presumptive omniscience is a dangerous and destructive myth. Do today's eugenicists know more about what life is worth living than did St. Augustine, St. Francis of Assisi, Aristotle or Hippocrates? . . ."

ACCL Update

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Marjory Mecklenburg, President

Joseph Lampe, Executive Director

Gloria Ford, Editor

The ACCL, Inc., Education Fund is the research, education and policy analysis division of American Citizens Concerned for Life, a national citizens' action organization engaged in educational, legislative, research and service activities that promote respect and protection for human life. The Education Fund focuses its concern on the troubled mother, the family, children — born and unborn — and other vulnerable members of society

BOOK REVIEW

Euthanasia's many faces

Reviewed by JOSEPH M. BOYLE JR.

"Death, Dying and Euthanasia," edited by Dahnia Horan and David Mall, Washington, D.C.: University Publications of America, 1977. (Available now from ACCL for $8).

Dennis Horan and David Mall have performed — still another — great service to the pro-life cause by editing "Death, Dying and Euthanasia." This 817-page anthology on the issues lumped together under the title "euthanasia" is the best book of its kind; no other single volume contains anything like the amount of carefully reasoned discussion of these complicated issues. For this reason alone: the Horan/Mall volume should be in every pro-life library and should be made available to all who must deal with the ethical and legal problems of death and dying.

The articles, excerpts and analyses assembled here do not make for easy reading. For the most part they are the results of the professional work of lawyers, physicians and academicians. Most of the treatments are scholarly and not journalistic. This allows for the nuanced and rigorous discussion which is part of the value of the book. Moreover, this careful and scholarly treatment makes clear the complexity of the issues we face as the euthanasia debate begins to take center stage.

The book is divided into seven sections prefaced by a clear and useful introduction by Dennis Horan. There is a section on defining death, one on the treatment of defective newborns, and three sections on euthanasia — one each on ethical aspects, legal aspects and social attitudes and governmental policies. There is also a section on the treatment of the dying and one on suicide.

Many of the selections are reprinted from books and scholarly journals. Some of these are classics — necessary background for anyone who is to understand the euthanasia debate. Leo Alexander's "Medical Science Under Dictatorship," Pope Pius XII's statement on ordinary and extraordinary means of medical treatment, Yale Kamisar's great critique of legalized voluntary euthanasia and Wertham's chapter on "The 'Euthanasia' Murders" are some of these.

Some of the other reprints are destined to be classics: for example, Paul Ramsey's "The Indignity of Death With Dignity" and James Gustafson's invaluable discussion of a version of the famous "Johns Hopkins" case.

There are also a number of pieces written specifically for this volume. Of these the statements of Marshall McLuhan and Eugene Ionesco are very interesting. Editor Horan's comments on the living will and on the Quinlan case are also important and Germain Grisez's discussion of suicide and euthanasia — the basis of a forthcoming book — makes the moral case against these acts in a novel and persuasive way.

Not all the pieces collected here are pro-life. Those which are not are nevertheless important and deserve the careful attention of pro-life people. Joseph Fletcher's "Ethics and Euthanasia" states the pro-euthanasia case in a clear and forceful way. Glanville Williams' response to Kamisar has yet to be adequately answered.

Finally, it is necessary to note Robert Byrn's important legal study on refusing medical treatment. Together with several other articles related to "death with dignity" legislation, Prof. Byrn gives us much of what we need to approach intelligently the issue which will surely be the next if not the current — legislative battle we face.

(Joseph M. Boyle Jr. is an assistant professor of philosophy at the College of St. Thomas, St. Paul, MN.)

Child-abuse study indicts abortion

Mothers who have had several abortions are more likely than others to beat their living children, according to a study conducted by Dr. Burton G. Schonfeld of Prince Georges County General Hospital and Medical Center in Maryland.

Dr. Schonfeld, a child psychiatrist, is developing a system to detect parents who may become child abusers and help them through psychiatry, social programs, and other aid.

Further indications of a potential problem parent, according to the study, include a parent who has been married three or more times, a parent-to-be who is angry at the prospect of a child, a mother who ignores her newborn child, and a father who comes to the hospital maternity ward drunk.

The review of "On Human Care: An Introduction to Ethics," by Arthur J. Dyck, published in the January 1978, issue of Update, was written by Rev. William C. Hunt, director of the Newman Center at the University of Minnesota.

Pro-life efforts cross nation

Marches, prayer breakfasts, protests, banquets and fund-raising events marked the fifth anniversary of the U.S. Supreme Court decision legalizing abortion this year. ACCL members and friends participated in pro-life efforts across the nation Jan. 22 to express their respect for life in person, on placards and billboards and in the media.

In Washington, D.C., where police estimate 70,000 pro-lifers demonstrated, Sen. Orrin G. Hatch (UT) challenged: "Let's make right-to-life the number one human rights issue of 1978!".

Rep. Richard Nolan (MN) recalled the observance in Washington: "... I do have a vivid picture still etched in my memory of the day. One of the things I remember is the large number of dedicated people who travelled at their own expense to let their congressperson know of their support for a human life amendment. People of all ages, religions, cultural backgrounds and viewpoints joined together for a common cause — the protection of life. It was quite a remarkable sight.

"I met with approximately fifty people from Minnesota — most of them from the Sixth District. All of these people expressed deep concern over the protection of life and stressed their hope that a human life amendment is passed into law. As a strong supporter of the pro-life movement and a cosponsor of a human life amendment, I was extremely pleased about the results of the rally. I feel it had a definite impact on members of Congress — it certainly had an impact on me."

Seminar

ACCL President Marjory Mecklenburg gave the keynote address at a Respect Life seminar held on Jan. 22 at the University of Minnesota in Moorhead. "After five years," she said, "we know that the conflict accompanying the Supreme Court decision will not fade away until we find some way to solve the problems causing abortion to be so widespread.

"There are basic value conflicts," Mrs. Mecklenburg said. She noted our notion of freedom and rights and our view of the fetus and human beings in general. "The value we give to the fetus," she said, "affects and is affected by how we perceive other human beings.

"The word abortion elicits a strong response, strongly held and divided opinions. Most of the public still sees some reasons for abortion, and there are powerful groups on either side of the issue."

She said that one group wants to sanction all abortions and the other will accept none. "It's no wonder the public is divided. No one is speaking to them or reflecting their opinions.

ANNIVERSARY

IT CAN BE DONE:

A school offers a helping ha

Lauri was sixteen, a high school junior from Gallup, New Mexico. She is a middle child with a part-Indian and part-Anglo background. Her parents are married and both employed outside the home. Lauri became pregnant.

Ellen was a high school senior in Albuquerque, New Mexico, planning to graduate at mid-term. She is the oldest of eight children and has two very supportive parents who disapproved of the relationship she was having with a boyfriend. Ellen became pregnant.

Fortunately for both Lauri and Ellen they were able to enroll in the New Futures School (NFS) in Albuquerque during their pregnancies. NFS, a comprehensive program for school-age parents, offers educational, health and social services to young women and their families during a critical time in their lives.

The New Futures School has served some 1200 students since its opening in January, 1976, and is a project of the Albuquerque public schools. NFS is supported by various community, state and federal agencies, and by concerned individuals. It is housed in a public facility at 110 Broadway Blvd. NE, formerly used as a high school. Program enrollment is open, free-of-charge, to any pregnant adolescent.

Lauri chose to live at the Chapparral Home in Albuquerque where she planned to release her baby for adoption. She received financial assistance from the state health and social services department while at the home.

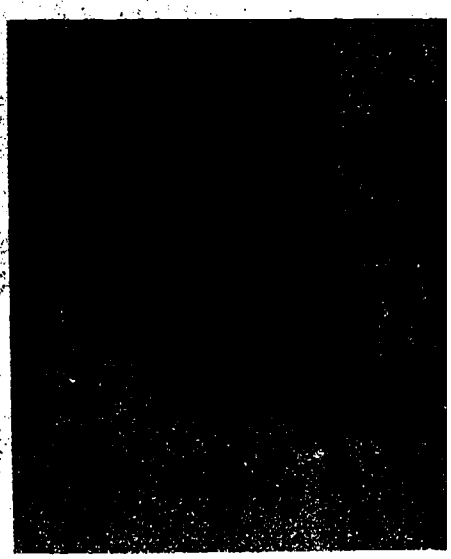
Ellen lived at home in Albuquerque and was given tokens to ride the city bus each day to NFS as part of the school's assistance program. Both girls were provided a nourishing lunch and snacks during the day according to their individual health needs.

New Futures, Inc., a private, non-profit agency, funds some services of NFS with $60,000 in grants and serves in an advisory capacity to the program. An additional grant of $40,000 will be used to develop educational materials for use by parents and educators.

Mrs. Caroline Gaston, program director, points to the high rate of return to school by students as one of NFS's successes. "Before NFS," she says, "almost one-third of the pregnant teen-agers in our area were dropouts. Now between 75-85% go back to school, progress toward a high school diploma and beyond.

Statistics like this were noted by the National Alliance Concerned With School-age Parents which selected NFS and Caroline Gaston for the 1978 National Award for Program Development and Administration, identifying the program as outstanding for school-age parents in the United States.

One of the most important decisions Lauri, Ellen and their classmates make while at NFS is whether or not to keep their babies. Mrs. Gaston reports that of 114 girls presently enrolled at NFS, 15% are releasing their babies for adoption. But the percentages vary; of the total enrolled thus far, 25% have released.



Approximately 40% of NFS students are married. Since national statistics on the success of teen-age marriages predict a divorce rate of 50% or higher the NFS staff believes that the married student can benefit from health and counseling services and the general and parenting education classes.

The teaching philosophy and techniques at NFS are geared to the needs of the students, and they are involved in the planning of the curriculum and in the evaluation of its effectiveness, Mrs. Gaston said.

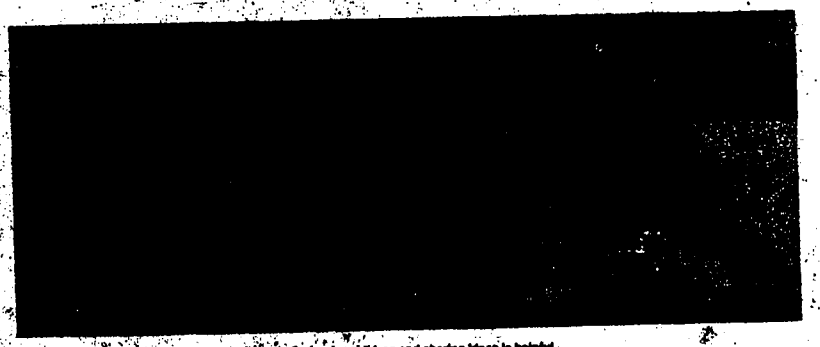
Family living, a semester course, is the only class required of all NFS students. It centers on the various aspects of being a pregnant teen-ager: her anatomy, physiology and care through the maternity cycle; the decisions she is and will be making; the understanding of herself and family relationships as she goes through this new experience.

Child development is also taught. Realistic expectations for children, parenting attitudes, and the emotional needs of children are explored, and stude laboratory experience in chil companying instruction.

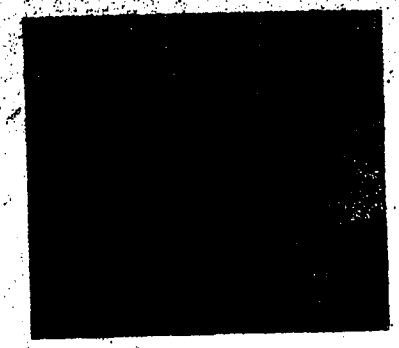
Class members participate the infants of NFS students. A instruction each girl must su plete infant care experie bathing, changing, prepa clothes washing, feeding, m and maintaining nursery hyg child-abuse is also included.

An infant care facility is a students. The nursery is us have no baby sitter available who are breast-feeding their some who are having probl their infants.

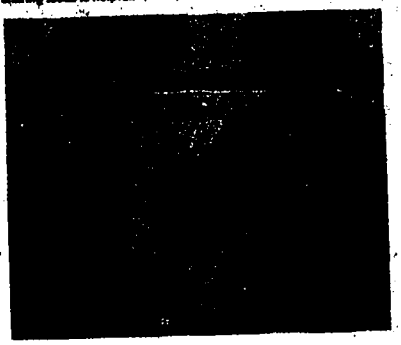
Other courses available to s communications, children's lish-reading improvement, making, cooking for fun, mat cal education, social studies hand, bookkeeping and biolog made through goal-setting the teaching of various skill



Caring for children and sharing ideas is helpful.



Teen-agers seek regular individual counseling.



Bathing baby is part of the learning and part of the fun.

students to the world of work.

The usual stay at New Futures is about five months. If a girl completes her high school graduation requirements while at NFS, she receives her diploma from her home high school. An NFS graduating ceremony, planned by graduating seniors, is held each May. A girl may decide which ceremony she prefers to attend. Ellen completed her high school work and chose to graduate in the NFS ceremony.

A health director, health assistant and family living specialist are employed at the school. The health director is a registered nurse who coordinates health services; the health assistant is an L.P.N., and the family living specialist is an R.N. with specialities in the pre- and post-natal needs of pregnant adolescents, human sexuality, family planning, and parenting education. The nurses participate in team-teaching the family living classes and serve as health resources for babies in the infant observation center.

An NFS nurse also visits the students at home following delivery to evaluate the home environment and the girl's post-natal adjustment. Referrals are made to other health agencies if the need exists, and the girl's plans for return to school are discussed with her.

NFS works closely with the Maternal and Infant Care Project, a federally sponsored program serving high risk mothers and infants. An M & I clinic is held at the school once a week. Most of the girls use the medical facilities of this project, assuring the health staff that each girl is seeing a doctor regularly and that her health care is being properly coordinated.

Lauri and Ellen found that a supportive atmosphere existed at NFS for them. They had the concern and empathy of other students as well as the attention of each teacher. Special counseling services were also available from four professionally trained counselors on the staff. Regularly scheduled individual counseling, as well as joint counseling with each girl and her mother, father, husband, or boyfriend is offered.

Since Lauri had already decided to release her baby for adoption, she met regularly with a group of girls releasing. She was a good student with a positive self-image and likeable personality, and she was fully aware that she was not ready yet for the responsibility of motherhood.

Ellen counselled individually and in groups with girls who were keeping their babies. Her mother also came to counseling sessions with her and with other mothers of NFS students. During her pregnancy, Ellen's sisters were seriously judgmental of her "goof up," and until after the baby was born, one sister even refused to talk to her. The father of the baby was also in and out of the situation. The services of a male counselor were available to him through NFS, but it was a very unstable and non-supportive relationship.

Follow-up services are an important part of NFS. Contacts are made with each girl during the summer after she leaves the program.

NFS

Continued on back page

Ex-stewardess pilots fund-raising

Fund-raising isn't everybody's cup of tea but for Sue Fremgen, ACCL's area representative from Illinois, it is just one of the things she can grasp, do well and call "fun."

Mrs. Fremgen initiated and coordinated the Love of Live Benefit, a fund-raising raffle organized by ACCL and sponsored by pro-life groups in eight states — Texas, South Carolina, Georgia, Maine, Iowa, Wisconsin, Illinois and Minnesota. Prizes, awarded on January 21, included a trip to the winner's choice of three popular vacation spots and a color TV set.

"Expenses were high this first year so proceeds were not as good as we expected," Mrs. Fremgen said, "but it was a successful effort and I see good things coming the next time around."

Mrs. Fremgen's interest in pro-life work started in March 1973, after the Supreme Court's decision legalizing abortion. She was a stewardess for Continental Airlines and a supervisor of stewardesses for the airline for four years. She organized and was vice-president of Stewardesses for Life, an informational pro-life organization. Slide show presentations between flights were some of the projects sponsored by the group for airline personnel.

Sue Fremgen

Mrs. Fremgen and her husband, Hal, helped found Illinois Citizens Concerned for Life and she is past president of the organization. She also helped establish and does fund-raising for the Care and Counseling Center in Illinois, a walk-in social service agency for women with troubled pregnancies.

"I really believe in the alternatives to abortion in the pro-life movement," Mrs. Fremgen said. She called the center and other supportive services "projects I can grasp."

Currently Mrs. Fremgen is working on a fund-raising project and slide presentation with Mary Gianni, a former American Airlines stewardess from Northridge, CA. The project, called "Fund-raising is Fun," will be shown at the National Right to Life Convention in St. Louis, MO, in June.

Mrs. Fremgen attended Endicott Jr. College in Beverly, MA, and received her undergraduate degree from Wayne State University in Detroit, MI. She has her master's degree in history from Northeastern Illinois University in Chicago. Mrs. Fremgen did her master's thesis on the history of the voluntary euthanasia movement in England during the nineteenth and twentieth centries. She is the mother of three children, Deborah (9), John (7) and Susan (5).

Mr. & Mrs. Watson

A trip of their choice — Mr. and Mrs. John Watson of New Limerick, ME, were "mystified" when first contacted by Sandra Faucher, president of Maine Right to Life (MRLC), with news that they had won a trip as the result of a Love of Life Benefit donation.

"We finally discovered the source of the winning chance," wrote Mrs. Watson, "our son, Danny Watson in East Millinocket, was selling chances for MRLC and bought one in our name. Our last donation to MRLC was in March 1977, and we were mystified until Danny called to tell us. He's as excited as we are."

The Watsons chose Hawaii as their destination and left Philadelphia on February 27 for a 10-day tour. Their plans include a five-night stay at the Hawaiian Regent in Honolulu, two nights at the Kona Hilton and two nights in Hilo at the Sheraton Waiakea. Planned activities, optional tours and free time, breakfasts and dinners are part of the tour.

The second prize, a color TV set, was won by C. Roy Rice of Portland, ME.

The Love of Life Benefit was co-sponsored by ACCL and other groups "organized to promote the common good" in eight states from October 1, 1977, through December 31, 1977. Winners were drawn by the National "Love of Life" Committee on January 21, 1978, at the St. Paul Hotel, St. Paul, MN. Proceeds are shared by ACCL and participating local and state groups.

Social worker joins care center staff

Johanna C. Miller, a certified social worker in the State of Illinois, has joined the staff of the Care and Counseling Center, a walk-in social service agency for women with troubled pregnancies, 6800 S. Main St., Downers Grove, IL.

Mrs. Miller, a professional counselor for the center, has a master's degree in social work from the University of Kansas. She has worked with unwed mothers and emotionally disturbed and abused children.

While employed by the State of Kansas, Mrs. Miller worked with foster parents and children in a comprehensive program of licensing, training and recruitment. She has also worked at a veteran's hospital, extended care facility, mental health and guidance center, and a suicide hotline.

Johanna Miller

Mrs. Miller, the mother of five children, and her husband, Lewis, live in Naperville, IL. She is a member of the Church of the Latter Day Saints.

CONGRESSIONAL ACTION REPORT

By JOSEPH LAMPE
and
SANDY SCHROEDER

In this newsletter column, current information is provided about congressional and state legislative activity which affects life. This report is intended as a source of information only and many bills are reviewed for which the Education Fund has no organizational position.

Legislation and Hearings Not Previously Reported

WITNESSES REACT TO 1979 HEW BUDGET

As of Mar. 10 the Administration had not yet put into final form its bill for an *Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1979*. The bill was expected to be transmitted to Congress for introduction later in the month.

The bill will be a primary authorizing vehicle for the HEW teen-age pregnancy initiative that is contained in President Carter's federal budget proposal. Dr. Julius Richmond, HEW Assistant Secretary for Health defended the proposed pregnancy initiative at a Mar. 2 hearing of the House Select Committee on Population. The budget figures are outlined in the following table:

The teen-age pregnancy initiative was strongly criticized at the Mar. 2 hearing by spokesmen of family planning and abortion organizations because of its heavy emphasis on providing comprehensive services to already pregnant adolescents and young mothers, as opposed to contraceptive services. These spokesmen also claimed that the amount to be authorized for comprehensive services is far too small to have an impact.

Frederick Jaffe of Planned Parenthood's Alan Guttmacher Institute called the Carter program a "grab-bag" of "empty rhetoric." Sargent Shriver, on the other hand, described for the committee the recent work of the Joseph P. Kennedy, Jr. Foundation in the area of adolescent pregnancy. He defended the concept of comprehensive services as necessary, cost effective and ethically required if we are to do justice to the many needs of young parents.

ADOLESCENT HEALTH, SERVICES, AND PREGNANCY PREVENTION AUTHORIZATION
(In millions)

	FY 1978		FY 1979	Change
	Ford	Carter		
New Legislation:				
Adolescent Health, Services, and Pregnancy Prevention Act	$ —	$ —	$ 60	$ +60
Expanded Medicaid Coverage for Low-Income Pregnant Women	—	—	18	+18
Current Law:				
Family Planning Services	66	83	101	+18
Community Health Centers	25	45	52	+7
Community Education	—	1	3	+2
Research and Demonstration	8	16	38	+22
Training	5	7	7	—
	$146	$196	$339	$142

FAMILY CONFERENCE TESTIMONY HEARD

White House Conferences are held on a number of topics to collect and document current insights that may suggest the need for national policy reformulations.

President Carter announced on Jan. 30 that "In order to help stimulate a national discussion of the state of American families, I will convene a White House Conference on Families in Washington, D.C., December 9-13, 1979."

The President also stated that "The main purpose of this White House Conference will be to examine the strengths of American families, the difficulties they face, and the ways in which family life is affected by public policies. The Conference will examine the important effects that the world of work, the mass media, the court system, private institutions, and other major facets of our society have on American families."

On Feb. 2 and 3 the subcommittee on child and human development of the Senate Committee on Human Resources held joint hearings with the subcommittee on select education of the House Committee on Education and Labor to consider plans for the proposed White House Conference on Families.

ACCL, concerned with the family as a vital institution in our society, submitted a statement for these "oversight" preliminary White House Conference hearings. (See related story in this issue).

Continued on page 8

Congressional Action Report

TITLE X BILLS INTRODUCED

On Feb. 24 a hearing was held by Sen. Alan D. Cranston's (D-CA) subcommittee on child and human development of the Senate Committee on Human Resources to consider a revision and extension of the Family Planning Services and Population Research Act of 1970 (Title X of the Public Health Services Act).

The legislation discussed was S.2552, introduced by Sen. Cranston and also sponsored by Senators Harrison A. Williams (D-NJ), Donald W. Riegle (D-MI), and Jacob K. Javits (R-NY), which would extend the authorization of appropriations for family planning services, population research, and related activities for an additional five years. Title X of the Public Health Services Act deals with grant support for family planning services and research into population and reproduction dynamics.

Some witnesses representing family planning organizations at the hearing accused HEW of abandoning its commitment to serve all low income women and of opting instead to provide services for teen-agers. Dr. Philip Lee of the Alan Gutmacher Institute said that:

> The Carter Administration proposal amounts to a policy of continuing to starve the one federal family planning program that has demonstrated its ability to reach and serve large numbers of sexually active teen-agers before their first pregnancy. The Administration's approach apparently reflects a judgment that it is more important or more feasible to attempt to help pregnant teenagers bear their babies than to prevent the first crucial adolescent pregnancy.

The subcommittee will have a markup session in early April to decide whether there should be any changes in the legislation and what the level of funding should be.

The *Alternatives to Abortion Act of 1978*, S.2614, which would amend Title X of the Public Health Service Act to provide alternatives to abortion, was introduced Mar. 1 by Sen. Jesse A. Helms (R-NC) and referred to the Senate Committee on Human Resources.

The *Alternatives to Abortion Act* proposes to redirect some of the efforts of the federal government from population and family planning programs toward the establishment and development of alternatives to abortion programs to help provide counseling and other assistance which is now not widely available. According to Sen. Helms, "It would enlarge women's freedom of choice by offering them viable, realistic, alternatives to abortion."

The bill mandates that not less than 40% of the amounts appropriated under Title X of the Public Health Service Act shall be expended on alternatives to abortion legislation. Title X authorizes currently a total of $182,500,000.

On Feb. 21 the subcommittee on health and the environment of the House Interstate and Foreign Commerce Committee held an authorization hearing on extension of the Title X family planning programs. The bill considered, H.R.10553, introduced by Reps. Paul G. Rogers (D-FL) and Tim Lee Carter (R-KY), would extend Title X for one year and increase its authorization level by 15 percent.

At the hearing Rep. Anthony Beilenson (D-CA) presented a bill he had introduced a few days earlier that would greatly expand the federal government's family planning and population research efforts under Title X. Stating that "there is no better alternative to abortion than contraception," Rep. Beilenson offered his bill as a substitute for the subcommittee's draft bill and as a response to the Carter administration's teen-age pregnancy initiative. Beilenson said, "I do not think [the Carter] package offers the kind of approach that will be necessary if we are truly interested in trying to help alleviate these problems in a meaningful way."

His bill, H.R.11007, the *Comprehensive Family Planning Services, Research in Human Reproduction and Prevention of Teen-age Pregnancy Act of 1978*, is based on the recommendations of a major Planned Parenthood publication released last summer. It would:

- Expand the family planning clinic system with project grants to enable 500,000 new persons to be brought into the system in each of the next three years.
- Provide project grants for family planning services to reach 500,000 teenagers each year.
- Provide a small grant program for demonstration projects in infertility services.
- Authorize locally-initiated projects of community-based organizations such as youth organizations or community centers to receive federal funds to reach and educate teen-agers about sexuality, family life, reproduction and fertility regulation.
- Centralize the management of the federal family planning program by mandating the direct administration of services, grants and contracts by the Deputy Assistant Secretary for Population Affairs.
- Greatly expand biomedical, contraceptive and behavioral research efforts.

Overall, H.R.11007 would authorize $325.3 million for Title X family planning and related programs, nearly $100 million more than the administration's request. The subcommittee's markup session on the Title X authorization bills was to be held in mid-March.

ALCOHOLISM EFFECTS STUDIED

The *Families with Alcoholism Assistance Act of 1977*, S.2295, was introduced last Nov. 4 by Senators Orin G. Hatch (R-UT), William D. Hathaway (D- MA), and Harrison A. Williams (D-NJ), and referred to the subcommittee on alcoholism and drug abuse of the Senate Human Resources Committee.

S.2295 will "amend the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 to provide emphasis within the National Institue on Alcohol Abuse and Alcoholism for families of alcohol abusers and alcoholics."

The *Families with Alcoholism Assistance Act of 1977* will help to focus the attention of the National Institute on Alcohol Abuse and Alcoholism, and of the individual states, on the needs of these families. Recognizing the substantial impact that alcohol abuse has on the families of alcohol abusers and alcoholics it:

Requires the States to survey the need for education, counseling and treatment of the families of alcohol abusers and alcoholics and provide assurance that programs within the State will be designed to meet such need;

Authorizes grants and contracts to provide education, counseling and treatment for the families of alcohol abusers and alcoholics;

Provides for programs and services, including education and counseling services for the benefit of the families of alcohol abusers and alcoholics; and

Authorizes research which places special emphasis on the impact of alcohol abuse and alcoholism on the family.

Hearings will be held soon on S.2295 in the subcommittee on alcoholism and drug abuse but the dates have not yet been set.

H.R.9699, *The Families with Alcoholism Assistance Act of 1977*, identical to the Senate version, was introduced last November by Rep. Marjorie S. Holt (R-MD), and referred to the House Committee on Interstate and Foreign Commerce. The legislation attracted a number of new cosponsors and consequently was reintroduced on Mar. 1 as H.R.11221. No hearings have been scheduled.

S.1464, *The Alcohol Labeling Bill*, was introduced last May 5 by Sen. Strom Thurmond (R-SC) and referred to the Senate Committee on Human Resources' subcommittee on alcoholism and drug abuse.

Sen. Thurmond's bill would require all alcoholic beverage labels to read: "Caution: Consumption of alcoholic beverages may be hazardous to your health and may be habit forming, and may cause serious birth defects when consumed during pregnancy."

Continued on page 6

Congressional Action Report

Action Taken on Bills Previously Reported

ALCOHOLISM

Continued from Page 8

The Bureau of Alcohol, Tobacco, and Firearms (BATA) published an advance notice of proposed rulemaking for warning labels on bottles of alcoholic beverages in the Jan. 16 Federal Register.

The notice was issued by BATA to obtain information enabling it to decide whether the alcohol regulations should be amended to require a warning label on alcoholic beverage containers, regarding the consumption of alcohol by pregnant women. The Bureau is particularly interested in comments from consumers, industry, women's' organizations and medical experts concerning the business impact and technical aspects, scientific and legal aspects, and the possible overall value and benefits of the proposal.

Comments were to have been received on or before March 17. The Bureau will evaluate all comments received.

On Jan. 31 the alcoholism and drug abuse subcommittee held a hearing on S.1464 to obtain testimony about warning labels on alcoholic beverages, the Fetal Alcohol Syndrome and other potential dangers to pregnant women. No markup session on S.1464 has been scheduled.

On Feb. 2, the subcommittee on employment opportunities of the House Education and Labor Committee reported out H.R.6075, the *Pregnancy Disability Benefits Bill*, which prohibits sex discrimination on the basis of pregnancy, rejecting the anti-abortion amendment offered by Rep. Edward P. Beard (D-RI).

On Mar. 1, however, the full House Education and Labor Committee not only approved H.R.6075 by a vote of 25-6, but also amended the bill on a vote of 19-12 to allow employers to exclude coverage of abortion from health and sick leave plans, except in those circumstances where the life of a pregnant woman would be endangered. The amendment approved states that:

> As used in this subsection, neither 'pregnancy' nor 'related medical conditions,' as they relate to eligibility for benefits under any health or temporary disability insurance or sick leave plan available in connection with employment, may be construed to include abortions, except where the life of the mother would be endangered if the fetus were carried to term; provided, however, that nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.

The *Pregnancy Disability Bill* is now awaiting action on the House floor. The Senate version of the bill passed last September without abortion limitations.

HOMEMAKERS BILL ADVANCES

A revised version of S.418, *the Displaced Hpmemakers Act*, identical to Rep. Yvonne Burke's (D-CA) H.R.10270, was introduced on Jan. 30. The bill "amends the Comprehensive Employment and Training Act of 1973 to establish a program of assistance to multipurpose service centers for displaced homemakers and for other purposes."

CETA hearings have been held in the subcommittee on employment, poverty, and migratory labor of the Senate Committee on Human Resources and at the Mar. 2 hearing Sen. Birch Bayh (D-IN) testified in support of S.418 as an amendment to CETA. The direction of S.418 is uncertain at this time.

Partial hearings have also been held in the employment opportunity subcommittee of the House Committee on Education and Labor, and as yet H.R.10270, Rep. Yvonne Burke's *Displaced Homemakers Assistance Act*, amending CETA, has not come up.

In both cases the legislation attempts to integrate a job training and placement program for older women into already existing federal programs under the Comprehensive Employment and Training Act, while at the same time, retaining those features of the original legislation which address the specific needs of this category of disadvantaged workers.

No Action Since Last Report

Bill #	SPONSOR	DESCRIPTION	COMMITTEE	SUBCOMMITTEE
SENATE				
S.370	Jacob K. Javits (R-NY)	National Health Insurance for Mothers & Children Act	Human Resources	Health & Scientific Research
S.1071	Gary W. Hart (D-CO)	Comprehensive Maternal & Child Health Protection Act	Human Resources	Child & Human Development
S.1382	Abraham A. Ribicoff (D-CT)	Child Health Assesement Act	Finance	Health
S.1468	Harrison A. Williams (D-NJ)	Black Market Baby Bill	Judiciary	Juvenile Delinquency
HOUSE				
H.R.408	Elizabeth Holtzman (D-NY)	Privacy Protection for Rape Victims Act	Judiciary	Criminal Justice
H.R.1702	James H. Scheuer (D-NY)	Maternal & Child Health Care Act	Interstate & Foreign Commerce	Health & Environment
H.R.1914	Joe D. Waggonner (D-LA)	Limiting Jurisdiction of the Supreme Court & District Court	Judiciary	Courts, Civil Liberties & Admn. of Justice
H.R.2826	Henry J. Hyde (R-IL)	Black Market Baby Bill	Judiciary	Criminal Justice
H.R.4273	Philip M. Crane (R-IL)	Limiting Jurisdiction of the Supreme Court & District Court	Judiciary	Courts, Civil Liberties & Admn. of Justice
H.R.5019	James L. Oberstar(D-MN)	Amends the SS Act to provide AFDC for the unborn	Ways & Means	Health
H.R.5708	Paul G. Rogers (D-FL)	Child Health Assesement Act	Interstate & Foreign Commerce	Health & Environment
H.R.6872	William C. Whitehurst (R-VA)	Prohibits use of federal funds-research on human fetuses	Interstate & Foreign Commerce	Health & Environment
H.R.8580	Henry J. Hyde (R-IL)	Federal Constitutional Convention Amendment Act	Judiciary	Civil & Constitutional Rights
H.Res.26	Silvio O. Conte (R-MA)	Select Committee to study Supreme Court decisions on abortion	Rules	Rules & Organizations
H.Res.66	Robert A. Roe (D-NJ)	Select Committee to study Supreme Court decisions on abortion	Rules	Rules & Organizations

ACCL statement

The Pregnancy Disability Bill, H.R. 6075, is expected to reach the House floor for a vote by mid-April.

ACCL representatives testified at both the Senate and House hearings in support of this legislation. ACCL is the only pro-life group that is a member of the National Campaign to End Discrimination Against Pregnant Women, which has worked to draft and pass this bill. Labor organizations, NOW, ACLU, and various church and professional groups are also members of the coalition.

Passage of H.R. 6075 will remove some of the economic pressures on pregnant working women that may cause them to seek abortions (abortions usually are covered by employer medical insurance plans, whereas maternity leave and medical expenses very often are not granted if the pregnancy is continued). H.R. 6075 seeks to rectify this unfortunate situation.

The Senate passed the companion bill, S.995, last fall with no amendments (see October Update). The full House Education and Labor Committee recently approved the bill and also approved Rep. Beard's conscience clause amendment clarifying that it is not the intent of the legislation to mandate payment for abortions (see report in this Update). In effect the Beard amendment allows an employer "freedom of choice" on the matter of whether to cover abortion-related expenses in his employees' health and disability insurance plans.

ACCL supports this bill and Rep. Beard's amendment and recommends that you contact your representatives to urge that they vote for the bill. House passage of the bill as reported to the floor by the Education and Labor Committee seems likely.

ANNIVERSARY

Continued from Page 5

"Too little is being done," Mrs. Mecklenburg believes, "to minimize problems causing abortion. "People are getting hurt, and nothing very concrete is being done to give women other choices.

"Why do women choose abortions? Because they don't perceive any other way to cope. Unaware of the biological facts of what a fetus is, they cannot identify with it as a member of the human family." Also, Mrs. Mecklenburg observed that the adolescent is not getting the help needed. She suggested that these problems could be taken up in the legislative and informational areas.

"Where are we going to be five years from now?" she challenged. "Will we be able to shift the balance, create a more caring society, replace abortions with less conceptions and provide other solutions to unwanted pregnancies?"

Earlier in the day, Mrs. Mecklenburg gave the homily at the university Newman Center. She remarked that it was Christian Unity Sunday and particularly appropriate that a Methodist deliver a homily on abortion for a Catholic mass.

"Concern about abortion is the legitimate concern of all religions," she said, "and opposition to abortion can be based on religious principles . . . The people who are involved all have a right to be involved, and any number of religious backgrounds lead one to the same conclusion.

"A Christian has a special perspective on the issue," she said. "Life is from God. Every life has a purpose. We are our 'brother's keeper,' and we have a responsibility for others. We have to be concerned with others' actions."

"We can pass a law to protect the unborn," she said, "but there is also an obligation to help those who have problems, to promote responsible sexuality and parenthood.

"We have a special opportunity as Christians to show how Christ would react to people who are having problems," she concluded.

Rallies

Representative James Oberstar (MN) addressed the Jan. 22 rally at the St. Paul capitol building in Minnesota. He told the 4,000 pro-lifers assembled that he was convinced that if support in the days ahead is as strong as it was that day, "we'll pass that amendment here and in Washington."

Oberstar said "I have never seen so much love and so much strength expressed in any other movement in American political history. There is no selfishness in this right-to-life movement."

Jean Garton, ACCL board member, spoke to approximately 500 people at a rally in Tucson, Arizona, on Jan. 21. She shared the platform with Sen. Joan Gubbins (IN), who spoke primarily about the International Women's Year (IWY). Sen. Gubbins led the Indiana IWY delegation. She is very pro-life and pro-family, Mrs. Garton said.

On Jan. 22 Mrs. Garton spoke to 200 gathered for a memorial service at St. John's Lutheran Church in Pekin, IL. The service was sponsored by Pekin Right to Life.

Prayer Breakfast

About 250 pro-lifers from Maine attended a prayer breakfast in Augusta on Jan. 28 — one week later than planned due to weather conditions.

The Rev. Robert Holbrook, national president of Baptists For Life and a member of ACCL's board of directors, had been scheduled to speak on the 21st and sent a recorded message due to the change of schedule. Messages were also read from Rabbi David Novak, ACCL board member and pastor of Beth El Congregation in Norfolk, VA, and the Rev. Edward C. O'Leary, Roman Catholic Bishop of the Diocese of Portland, ME.

Participants in the interdenominational worship service represented a variety of Protestant and Catholic churches in the state.

Sandra Faucher, president of the Maine Right to Life Committee, reminded the group that although there are many obstacles to their cause, God's help should be sought to make the right decisions.

Biblical understanding of the gift of life was stressed by the Rev. Desmond Parker of the Dover-Foxcroft Methodist Church. "Each child has the potential to be great, wonderful, saintly or simply Christian," he said.

The Rev. Grayson Schwarz, pastor of the Cox Memorial Methodist Church in Hallowell, said that the real handicapped in the world are those who use economic productivity as the criterium of a person's worth. "If you've got your health," said Rev. Schwarz, "you haven't got it all. There's a lot of miserable people walking around who have got their health."

SUPREME COURT TO HEAR NEW CASE

The United States Supreme Court agreed on March 6 to hear the appeal of another major abortion regulation case. The justices announced they will rule next year on the states' power to require that doctors doing late abortions attempt to save the lives of potentially viable fetuses.

Pittsburgh attorney and ACCL board member Carol Mansmann will defend this provision of the 1974 Pennsylvania Abortion Control Act during oral arguments on the case before the Court in October. Mrs. Mansmann, who is a professor of women's law at Duquesne, and her husband, J. Jerome Mansmann, were appointed special attorneys general for the Commonwealth of Pennsylvania to defend the Act.

The Pennsylvania law requires doctors to protect rather than end the life of the fetus if "there is sufficient reason to believe the fetus may be viable." If upheld, the law might discourage doctors from performing abortions beyond the 20th week of pregnancy.

A three-judge federal panel found the laws unconstitutional but the state appealed the decision. The U.S. Supreme Court sent the case back to the district court for a review in light of its ruling on the 1976 *Danforth* case in Missouri.

But the Pennsylvania district court again maintained that it was unconstitutional to require doctors to keep a viable fetus alive. The Supreme Court has now agreed to the state's request for a second review of the law.

March of dimes reaches out in new directions

A forthcoming cutback in funding for genetic services by the National Foundation of the March of Dimes has generated surprise, speculation, criticism and misunderstanding.

The cutback was announced by Dr. Arthur J. Salisbury, M.D., vice-president for medical services for the foundation, at a meeting in December sponsored by the Public Health Service Genetics Coordinating Committee at the National Institute of Health, Bethesda, MD.

Some recipients of March of Dimes grants for genetics services blamed pro-life opposition to the use of amniocentesis, funded in some programs when it is used to detect untreatable conditions that could lead to abortion, as the cause of the cutbacks.

Some pro-life groups have been actively critical of the March of Dimes and speculated that their lack of support caused decreases in fund raising leading to the decision.

But Dr. Salisbury emphatically denies that pro-life pressure caused the cutoff or any change in policy. "Public support of the March of Dimes has more than doubled since 1970," he says, "from $24,743,286 to $57,695,449 in 1977. The increase from fiscal year '76-'77 was $3,277,000."

Nor is there a change in policy, according to Dr. Salisbury. The philosophy of the March of Dimes is to act as a "catalyst," and its function in funding medical services is "to provide initial seed money necessary to demonstrate the need for and value of new services, not to fund static programs in perpetuity," he said.

The March of Dimes recognizes that the *National Genetics Disease Act* (P.L. 94-278), approved by Congress in 1975 but never funded, is due to expire in 1978, and that March of Dimes seed money has become the major source of funding for genetics service units, increasing the number of units from fewer than 10 in 1970 to more than 100 today.

The National Foundation has actively supported the funding of the *National Genetics Diseases Act* as an alternative source of long-term support for these programs. Dr. Salisbury believes the funding of the act is absolutely critical to the survival of genetic services in the long run.

Dr. Salisbury said the foundation's concern about the loss of life and permanent damage resulting from the lack of availability, accessibility and use of comprehensive, high quality prenatal and perinatal health services would be reflected in new funding, increased local community efforts and educational approaches.

Youth involvement in March of Dimes work is a growing feature of the foundation's program.

On Nov. 16 last year a capacity crowd of 1,500 teen-agers and teachers from public and private junior and senior high schools throughout Minnesota filled the St. Paul Civic Center Theater for the eleventh annual Minnesota Youth Conference, entitled "being Born Century III."

Hymie Gordon, M.D., chairman of medical genetics at Mayo Clinic and an ACCL board member, gave one of the keynote talks with an accompanying slide show. Dr. Gordon emphasized the importance of discovering genetic inherited traits and dealing with them through counseling.

The Youth Conference featured medical and public health experts and a variety of workshops including adolescent psychology, nutrition, parent readiness, effects of drugs and alcohol, the realities of living with a handicap, environment, teen-age health services, genetics, venereal disease, perinatology and health field careers. The relationship of each in promoting good mental and physical health, subsequently lowering the incidence of birth defects, was explored.

Advertisements for this year's Mother's March and general fund raising stressed "Protect the newborn and the unborn," indicative of the new emphasis March of Dimes intends for prenatal and peri-natal care.

Director installs computer

Joseph Lampe, ACCL executive director, is shown at the console of the organization's new microcomputer system. Mr. Lampe built and programmed the multi-purpose computer, which will be used for record keeping, accounting and text editing.

The system is believed to be the first microcomputer installed in the office of a pro-life organization. According to Mr. Lampe, many small businesses, and even home hobbyists, are beginning to use this latest generation of small, inexpensive computers for a variety of tasks.

Conversion of ACCL's membership and newsletter subscription records to the computer system is nearing completion, and it was used to print mailing labels for the January and March issues of Update.

Mr. Lampe requests contributors to use the following blank to update ACCL's information by correcting name and address if necessary and by including congressional district and phone number.

(With YOUR help, ACCL will be able to maintain complete, accurate and

TEEN-AGERS

Continued from Page 1

at only one, or a few, of these needs will likely prove inadequate."

She cited many professionals and supportive service programs recognizing the need for a total approach, including the statistical findings of their work.

Mrs. Mecklenburg noted that "Adequate services for pregnant adolescents are, at present, provided in only scattered locations in the United States. Only one state (Delaware) has a publicly funded, statewide program that attempts to reach all school-age parents. Comprehensive care projects offering services specifically tailored to the needs of adolescents exist in a few metropolitan areas. But in most areas such services are spread among many agencies, or are nearly non-existent.

"Overall statistics on the availability of comprehensive pregnancy services are incomplete. One major survey, the National Directory of Services for School-Age Parents, catalogs a variety of services for adolescents, including adoption agencies, crisis counseling centers, family planning organizations and abortion clinics, but lists only a handful of comprehensive pregnancy care projects."

The other panelists included: Monsignor James T. McHugh, director of family life division of the U.S. Catholic Conference; Ms. Joan Benesch, co-chairperson of the sex education coalition, Washington, D.C.; Dr. Joy G. Dryfoos, director of planning, The Alan Guttmacher Institute; Ms. Judith Jones, director of the adolescent pregnancy program, Center for Population and Family Health, Columbia University; and Harriet Pilpel, Esq., law partner in the firm of Greenbaum, Wolff and Ernst.

The recommendations of the ACCL testimony are:

To minimize the adverse social, economic and personal effects of adolescent pregnancy, ACCL recommends that:

1) comprehensive care programs be established wherever there is a significant population of high-risk adolescents.
a) in areas where this is not economically or demographically feasible, existing social and medical services be coordinated, modified and upgraded to assure that the needs documented above are met by families or public and private agencies.
b) to expedite this process, citizens' task forces be formed to survey how well pregnant adolescents' needs are being met locally and to develop plans for making available any missing elements of a comprehensive program.
2) state legislatures authorize and fund experimental programs similar to the Delaware Adolescent Program, Inc., in order to further evaluate their effectiveness.
3) the Congress authorize and fund teen-age pregnancy initiatives proposed by DHEW in the fiscal 1978 federal budget.
4) the Congress mandate nationwide eligibility for public assistance (AFDC) for low-income women during pregnancy (22 states do not permit this presently).
5) funding for the Women, Infants and Children Supplemental Food Program be universally available for those who qualify.
6) increased emphasis be placed on research in maternal and child health, reproductive biology and the etiology and behavioral dynamics of adolescent pregnancy and early childbearing.
7) legal, economic and other barriers be removed which might unduly bias the decisions of very young single mothers to keep rather than relinquish children.
8) family life and child development education for young adolescents be made more available.
9) programs of sex education and family planning be developed that are directed at the prevention of adolescent pregnancies and abortions.
10) public policies in this area be devised so they do not weaken or undercut mediating structures: those institutions closest to the control and aspirations of most Americans such as the family, neighborhood, church, voluntary association and ethnic subcultures. To be most effective, public policy where feasible should use mediating structures to advance the legitimate social goals of reducing the incidence and improving the outcome of adolescent pregnancy.

NFS

Continued from Page 5

and each summer thereafter. Items of particular conern are: number of repeat pregnancies, school grades, high school graduation, drop-out rate, physical health of the mother and baby, problems of family adjustment, adjustment to the role of mother or to the decision to give up the baby, successful marriage, emotional state, and post-graduate education or training.

In December, 1976, the office of Child Health Affairs concluded that when contraceptive programs are unavailable the frequency of repeat pregnancies for teen-age parents was 18% after six months, 44% after one year and 70% after two years.

NFS, with its comprehensive program of education, counseling and follow-up reports that the repeat pregnancy rate of NFS clients is 2% after six months, 6% after one year and 19% after two years. These figures include documented cases of contraceptive failures and also include planned pregnancies by married couples who are high school graduates and economically self-sufficient.

NFS followed up on Lauri and Ellen. Lauri had a six-pound, one-ounce baby girl with no complications. She released the baby through the Chaparral adoption agency as planned and returned to Gallup and her home school. She graduated and is enrolled in a nurse's training course in Arizona. She now has a boyfriend and is happy and pleased with her life.

Ellen had a seven-pound, 10-ounce baby girl with no complications. After graduation she worked at the telephone company, continuing to live with her parents. Her mother cared for the baby while she worked.

Ellen was awarded a financial assistance grant from the Altrusa Club to go to beauty college. For three years she worked, lived at home and raised her baby. She seldom dated and felt bitter toward boys. Now she has met and married a man who is good to her and to her daughter. Ellen is expecting her second child and is enjoying her marriage, daughter and part-time employment.

— by Gloria Ford

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Senator REIGLE. Let me, before we conclude, just make a couple of observations.

First of all, you have all made important suggestions to us in terms of ways to look at the bill and improve it. Most of what you say makes good sense to me.

I think it is important that we step back from that, and really think for a minute about where we are at this point. There is no question, but what there is an important national need for the kinds of initiative that is being talked about here.

The need for family planning services, the need for counseling, and advice, and help, and assistance to young women who become pregnant in their adolescent period, is just an enormous national need.

All the facts bear that out. It is so obvious that it is a case that stands on its own, just based on the documented knowledge that we have.

I am encouraged by the fact that the administration is recognizing that, and taking a good-faith step in the direction of trying to do something about it.

Now, we ought not to kid ourselves. I think that $60 million, to start with, is the tiniest beginning. It only, in a sense, is a sincere recognition of the problem, and a start. It is a fair start, and to move on from that, to the kinds of broad-scale initiative that is needed and that we can jutsify, and that is worthy, is an entirely different proposition, with the price tag that would be many, many times greater than the $60 million.

I think we are going to have trouble getting the $60 million because of the moment in time where we find ourselves. We ought to have been facing up to this problem years ago. This is not anything that is new. It is the fact that we are paying attention to it that is new.

Now, my concern is that as we watch this idea, and as we watch this effort, we do so at a time when there is so much counterpressure toward anything that involves an enlargement of the Federal Government activities, or outreach, that unfairly this particular issue will have to carry the burden of fighting off all those pressures at this time.

Now, I just want to say to you, and to the other constituency groups that are here, and within earshot, that care about this, that in order to be successful we are going to have to argue, more than just the merits of the case. We are going to have to put it in the context of the fight for a limited amount of national resources. There are people around here that want to spend a lot of money on the neutron bomb, and others on the B–1 bomber, and it goes right on down. Not just on the Defense budget, but on every other budget. The State and local governments also have a long, enlightening list that they feel the need to take on.

So I think that we not only have to make the argument for this program, based on the experience that we can look at to tell us that this needs to be done, and that it is humane, and it is a good dollar investment as well. I think we have to be just as tough and sensitive to how this relates to everything else, and the fact that we are going to have to compete for those dollars, and be more persuasive in doing so, and to show a higher justification, a higher need, a higher value in spending the money here.

This committee is the committee that attends to people who have the strongest feelings about this issue. So you will find on the Human Resources Committee, by and large, people who worry a great deal about these things, and spend a long time looking at them, and trying to figure out what we can do to deal with human problems, especially in this country.

Other committees of the Congress have quite different characteristics. They tend to be associated with the interests that come before those committees, be it Agriculture, or Defense, or what have you.

When we leave here, as I trust we will be able to with the bill with at least majority support of this committee, we go to the Senate as a whole, and to the House of Representatives, where it is a totally different ball game. I think, since Tuesday, and proposition 13, the struggle for resources here is an issue that immediately goes up and out from the particulars of the problems of preventing pregnancies, or dealing with pregnancies in adolescent youngsters in this country.

So I hope that we understand the context in which this debate and this struggle will be going on, because if we do not, we are not going to get very far, either in terms of getting $60 million, or beyond that, to the much more detailed and specific kinds of a program you have in mind.

There is no question but that we do it right, and evaluate efforts as we go along. Those are expensive. They are worth it.

The problem is that if we cannot get the money, then that may not have any bearing on the degree to which something is worth it. So I only conclude by again thanking you for your testimony.

But I want to again emphasize the fact that the main part of this struggle will not take place in this room in terms of laying out the facts of this case, but rather in going out and fighting for a larger share of national resources, a larger and more significant national priority for this kind of problem.

And, my goodness, if we are not going to respond to the needs of our young people, and to our young women who are faced with pregnancies that they do not in many cases want, that they do not understand, or to the youngsters who are born out of those situations, and who, as the data shows, are destined in most cases to live a life of misery for decades, then I think we really have our priorities wrong.

But to straighten that out is going to be a tough struggle right now, so I ask you to recognize that that is the fight that we are in. It is perhaps quite unfair that we should see that additional burden attached to the struggle to finally get this issue to the point where we do something about it, but that is the way it is, and so we have to work at this in that context.

I appreciate your testimony, and I appreciate the other witnesses that have appeared today, and we will consider your suggestions carefully, and do the best that we can.

The committee is adjourned.

[Whereupon, at 2:36 p.m., the committee adjourned, subject to the call of the Chair.]

ADOLESCENT HEALTH, SERVICES, AND PREGNANCY PREVENTION AND CARE ACT OF 1978

WEDNESDAY, JULY 12, 1978

U.S. SENATE,
COMMITTEE ON HUMAN RESOURCES,
Washington, D.C.

The committee met, pursuant to notice, at 10:05 a.m., in room 4232 Dirksen Senate Office Building, Senator Harrison A. Williams, Jr. (Chairman), presiding.

Present: Senators Williams, Riegle, Javits, and Chafee.

OPENING STATEMENT OF SENATOR WILLIAMS

The CHAIRMAN. We will please bring our committee hearing to order.

Today the Senate Human Resources Committee begins its second day of hearings on S. 2910, the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978.

This legislation represents a determined effort to attend to the alarming problem of adolescent pregnancy. Statistics indicate that approximately 1 million young women between the ages of 15 and 19 became pregnant last year, and approximately 600,000 of them gave birth. Demographic studies illustrate that there has been a steady decline in the number of adult pregnancies in the past 10 years, however, there has been a marked increase in the number of pregnancies of young girls 15 years of age and younger.

Experts who testified during the committee's first day of hearings on S. 2910 indicated that the health, social and economic implications of teenage pregnancy were considerable. In general, the younger the adolescent, the higher the medical, educational, psychological, social, and economic risk. For example, teenagers 16 years of age and younger have an increased incidence of prenatal complications, maternal and infant mortality, and infant morbidity including developmental disabilities, mental retardation, and neurological abnormalities. The committee further heard testimony that many adolescents who keep their babies become entrapped in a syndrome of poverty, Government dependency, repeat pregnancies, and family breakdown.

The complexity of the problem demands a comprehensive approach based on a national commitment to integrate health, educational, and social services in a coordinated effort.

At earlier hearings, we heard testimony from the administration, demographers and researchers, teenagers, as well as advocates for,

primary prevention efforts and for comprehensive care centers. Today we will hear from representatives of State and city governments, pro-life and religious organizations, educators, and other organizations interested in this problem.

The Secretary of the Department of Health, Education, and Welfare, Joseph Califano, has indicated that project grantees could be State and local agencies, schools, churches, and other facilities. Today's witnesses represent some of these groups, and should be extremely helpful to the committee in determining how we can best develop an effective national approach to encourage innovative, local experimentation to design, deliver, and coordinate pregnancy prevention and care in a manner best suited to community needs. Our committee looks forward to hearing these suggestions.

These hearings represent an attempt to gather information from a broad range of expert witnesses, and to provide a full opportunity for public participation in the legislative process. The testimony which we hear today will be of the utmost importance in shaping national legislation to improve the lives of our adolescent population.

We will proceed today with four panels, each group according to background, interest, and activity.

For the first panel I am glad to call the commissioner of the New York State Department of Social Services, Barbara Blum.

Good morning.

We will also hear testimony from: Mary Lou Blanchard, director, Family Services Division, Michigan State Department of Social Services, Mr. Abe Narkunski, director of Social Services, Atlantic County Department of Social Services, Atlantic City, N.J.; and Mr. Quentin R. Lawson, human resources coordinator, City of Baltimore, Md.

We are very, very pleased to start with you this morning and look forward to your testimony.

Commissioner Blum, you are listed first.

STATEMENT OF BARBARA B. BLUM, COMMISSIONER, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES, ACCOMPANIED BY MARY LOU BLANCHARD, DIRECTOR, FAMILY SERVICES DIVISION, MICHIGAN STATE DEPARTMENT OF SOCIAL SERVICES; ABRAM NARKUNSKI, DIRECTOR OF SOCIAL SERVICES, ATLANTIC COUNTY DEPARTMENT OF SOCIAL SERVICES, ATLANTIC CITY, N.J.; AND QUENTIN R. LAWSON, HUMAN RESOURCES COORDINATOR, CITY OF BALTIMORE, MD., A PANEL

Ms. BLUM. I am Barbara Blum, commissioner of the State Department of Social Services in New York State.

It is an honor and privilige to have this opportunity to testify before you today with regard to the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978.

In New York State we are very concerned about the issue of adolescent pregnancy. We are gratified that President Carter has developed legislation which embodies many of the principles necessary to address this issue, and to have a member of the New York delegation, Senator Jacob Javits, as a cosponsor of the bill.

Few issues in the State or in our Nation are as challenging as the subject of this legislation. The nurturing and rearing of children by

parents prepared for such rseponsibilities must be a national priority. In New York State, the commitment of Governor Hugh L. Carey to respond to the needs of young parents as well as to persons pregnant or at risk of pregnancy is clear.

In New York State, in 1976, there were 1.6 million females between 10 and 20 years of age. Among females age 15 to 19, there were 62,000 pregnancies at a rate of 78 per thousand females for that age cohort. These pregnancies resulted in 29,800 live births, with approximately 12,600 children—or 42 percent of such births—born out of wedlock. For females under age 15, there were 2,000 pregnancies, 640 children were born to these very young females, and of these, approximately 80 percent or 510 children were born out of wedlock.

These figures are dramatic. Viewing the State as a whole, the rate and number of pregnancies in both age cohorts has been increasing over the past 5 years.

As a result, in January 1978 the Governor directed the State department of social services in concert with other agencies, to insure that adequate family planning services exist for young females and that appropriate programs are provided for teenagers who are either pregnant or young mothers.

The department shares the Governor's belief that teenage pregnancy is a complex problem with social, education, health, and employment implications. Any resolution requires a comprehensive approach to the issues. Not only must care and services be provided to pregnant females and young parents; but those factors which are contributing to the prevalence of teenage pregnancy must also be addressed.

Over the past 6 months, the department of social services has been working with a variety of State agencies to identify service needs, inventory existing and potential programs and resources, and develop planning and program strategies. In addition, the department established a task force on teenage pregnancy composed of over 30 persons outside State government, who have knowledge and experience with issues related to teenage pregnancy. The purpose of the task force is to aid the department in defining services needs, identifying the types types of existing services and delivery systems in the community, identifying service gaps, and developing recommendations for actions to be undertaken at the local, State, and Federal levels of government.

In addition, the department invited commissioners of local social service districts to attend a meeting to discuss the problems and related programmatic issues in their particular counties, and based upon their experience and knowledge to propose recommendations for needed action.

Finally, the commissioner of the State department of social services has conducted throughout the State a series of public forums at which all interested persons and organizations were invited to testify concerning service needs. At each forum, numerous speakers gave testimony on the topic of teenage pregnancy and provided valuable insights.

As a result of these efforts, the department has prepared a report which contains data concerning teenage pregnancies in New York State, an analysis of existing programs, and recommendations for developing and expanding needed services and care. The Governor has received the report and has endorsed its recommendations. We are

pleased to be able to provide members of this committee with a copy of the report.

In our analysis of the factors which contribute to pregnancy at an early age, certain issues must be dealt with openly and honestly. Some females become pregnant because they do not know about, want to use, or have access to contraceptives; some females become pregnant as a means to achieving identity and worth; some females become pregnant because ways to achieve economic independence and employment do not exist—these are complex factors. Government alone cannot resolve many of these issues. There are, however, certain broad goals which should be the basis for our action.

Teenagers must have the opportunity for independence and self-worth. The education system and social, health, and employment systems programs all must participate to create an environment for independence. These systems and programs must be utilized in a manner to support the family both to teach values and to function as a supportive system throughout life.

Broad goals such as these require that social, health, educational, and employment services be available to teenagers who become pregnant. Policies and programs cannot be solely reactive in nature; the need for preventive services and care is evident. A continuum and diversity of programs is required. Programs must be more effective and accessible, and additional services and care must be developed and expanded.

More specifically, the program strategy must include: Primary prevention which involves the education of young children concerning the importance of human relationships and the responsibilities of family life.

There is an overriding need to educate young children, adolescents, and teenagers concerning the importance of human relationships and the responsibilities of family life. This includes development of self-esteem, self-knowledge, decisionmaking skills, interpersonal skills, and sex education and parenting skills.

Such an educational process should be a continuous one from infancy through young adulthood, and should be the responsibility of parents, the formal education system, and other institutions and groups which are significant in a child's development—the church, youth organizations, et cetera.

Secondary prevention which includes services and counseling for young adolescents and others to enable/encourage informed choice about sexual activity and contraceptives.

Family planning services must be available and accessible to adolescents. The most appropriate locations for such services may vary locally and may include: Family planning clinics, neighborhood health centers, school health services, youth centers, college health centers, private physicians, et cetera. But the important factor is to be sure that such services are available where teenagers actually "hang out."

In addition, other services must be available and accessible as a preventive measure: Educational services, and employment/job training counseling and services; services and care for pregnant adolescent and others.

A pregnant adolescent must be provided with information about all alternatives regarding pregnancy and necessary care and services. Early determination of the pregnancy is essential.

For adolescents who choose to terminate pregnancy, early services and counseling should be made available so as to minimize the risk of late intervention and to insure that subsequent unwanted pregnancies do not occur. For those choosing to continue pregnancy, early prenatal care should be made available. In addition, services and care must be provided to minimize long-term dependency. To the degree possible, such services and counseling should incorporate the needs and emotional support of the father and the family.

Service and care should seek to minimize long-term dependence, and to the degree possible, should recognize the responsibility of the father and the family. Such services must be accessible to the client in a manner which will encourage and permit continuing education and/or employment.

From the comprehensive context, we believe that the proposed Federal legislation provides a meaningful first step to resolve the problem of adolescent pregnancy. The bill addresses the problem from both preventive and remedial perspectives, by providing funds for a range of care and service. The legislation permits flexibility in regard to the types of services which may be funded. Funds would be available through this legislation to insure linkage among services, and for an all too often forgotten element—training.

Finally, the bill does not set specific eligibility requirements for needed care and services.

In New York, we believe these principles provide an appropriate basis for a sound program strategy. To deal with the teenage pregnancy issue comprehensively, care and services must be made available to adolescents who choose to become parents. The major emphasis, however, must be on prevention if we are to change the current situation.

A variety of care and services must be available, and these will vary from locality to locality. In some communities in New York State, there are numerous programs, operated by private and nonprofit agencies, such as settlement houses, youth centers, and neighborhood centers which currently are a major source of services. In these situations, there is a need to build upon such services and service delivery systems and insure coordination and access.

In other communities, there are minimal services, and the issue is not service expansion but service development. This bill addresses the needs of both situations. The bill also stresses the importance of access and linkage among essential services. Assuring access is particularly important in rural areas where transportation is not readily available. In addition, program coordination and case management are all too often lacking, so that many service providers are not aware of other available services.

The problem of adolescent pregnancy exists in all communities, and is not limited to those persons receiving public assistance. Increased sexual activity is common among adolescents of all income levels. For example, based upon the number of births for the past several years, it can be estimated that there are currently 94,000 children of parents under age 20.

However, a survey of AFDC cases in March 1977, indicates approximately 15,000 children in public assistance households with mothers 20 years of age or younger. Although this a low estimate because of the lack of data on combined households, this figure does suggest that a large proportion of teenage parents are not public assistance recipients. This legislation is of particular value because income eligibility requirements are not established.

At the same time, there are aspects of the proposed legislation which we believe must be changed if this legislation is to have a fundamental and constructive impact upon the problem of adolescent pregnancy.

First there is the issue of planning and coordination. The bill would permit any State, local, or private nonprofit agency to apply for funds to provide and/or insure linkage of care and services. A fundamental problem in New York State has been the lack of program planning and coordination among State agencies and between local, State, and Federal programs.

Wherever the funds associated with this legislation are channeled, there must be a requirement for broad, comprehensive community-based program planning and coordination as a prerequisite. We do not need one more source of funds which is administered in a manner uncoordinated from other programs, or is not based upon sound planning.

We believe the best way to insure sound planning and resource allocation is through grants to the States, with requirements for statewide, community-based planning, and criteria for funding allocations and program accountability.

If Federal grants are allocated directly to the local providers, there will continue to be a tendency for areas which have minimal expertise but a critical need not to receive funds. For example, in New York State, the counties with the highest rates of pregnancies and live births and the greatest increases in those rates are the more rural and semi-rural counties.

This approach of direct funding of local organizations exacerbates planning difficulties when funds also flow to the localities from various State and local private sources as well. The greater the number of sources of funds, the greater the probability of no coordination.

An example of these issues is the use of Federal and State family planning funds in New York State. Excluding medicaid, over $10 million is spent, which about half is provided by direct Federal Title X grants to local agencies. These providers are predominantly in the more urban areas. The major conduit of the remainder of the family planning funds is the State health department. Yet the department has had limited success in developing joint planning and coordination with HEW as to how best to utilize all these funds.

We believe that funds should be allocated to the States with strict criteria for planning and coordination. In New York we have begun such a statewide planning effort. We have already developed substantial statistics on a county-by-county basis. In the next several months we will begin a county-by-county survey of existing programs, among both public and private sources. And we are beginning efforts to allocate funds among the many programs, based upon the severity of the problem in localities and in a coordinated manner among agencies. We

believe this is the approach which should be utilized to address the critical issues associated with adolescent pregnancy.

Besides the issue of coordination and planning, we believe that there should be a greater degree of flexibility in how the funds are utilized. The proposed legislation would require that no more than 50 percent of funds be utilized for care and services. The bill would not permit funds to be used for services and care which can be funded from other sources.

It is important to stress that needs vary from locality to locality. Certainly all communities require expanded or developed services and improved access and linkage among services. But it is inappropriate to suggest limits on how funds should be utilized. It would be more appropriate to require that all proposals incorporate basic specific services, linkages, and planning functions, or proof that one or more of such functions does not require additional funding. To impose requirements on how the funds must be used does not take into consideration the varying needs among localities.

The bill also appears to place a low priority on funding certain supportive services. Specifically, the bill does not discus services associated with helping to make persons effective parents. We would argue that parent effectiveness programs are critical as an element of any program for young parents as well as any preventive program.

The bill excludes infant day care and employment programs. Infant day care is an important supportive service which can permit teenage mothers to continue their education and acquire employment. Job training, counseling, and employment are critical to minimize long-term dependency.

It is true that there are other funding sources to provide these services. But the employment programs such as CETA and the Youth Employment Training Act do not provide for, or do not provide a sufficient amount of the types of supportive services necessary to acquire and to maintain a job.

With regard to infant day care, we agree that such program costs should be funded through Title XX. However, you must be aware of the limited funds available in that program, and the increasing demands for services at the local level.

Obviously other relevant funding programs should be utilized to the maximum degree possible, but it is inappropriate to preclude certain services from funding through S. 2910.

The legislation also does not address the problem of public awareness. Increased sexual activity is common among adolescents of all income levels. In New York State there continues to prevail a lack of community awareness of or willingness to recognize the problem, and I am sure this is not unique to New York.

Any program strategy must begin with stimulating community awareness, for without community support, an effective response to the problem is not possible. Proper use of the media is crucial to creating public interest and understanding. We would recommend that S. 2910 permit funds to be used for this purpose.

Finally, while the legislation recognizes the importance of prevention, and the need for adequate services and counseling for young adolescents to enable informed choice about sexual activities and contra-

ceptives. We believe that true prevention must start much earlier. We must begin educating young children about the importance of human relationships and the responsibilities of family life.

As we noted earlier, such an educational process should be a continuous one from infancy through young adulthood, and should be the responsibility of parents, the school system, and others. The educational system has a major role to play, and this should be recognized and stressed. We say this for two reasons.

In New York there is wide variance among school districts as to what is taught, or more properly, what is permitted to be taught. This reflects community hesitancy, and an unwillingness by the educational profession to assume some degree of responsibility. Certainly, this situation is not unique to New York State.

For this reason we believe that any legislation should require school districts to assume an appropriate programmatic role both in terms of prevention and by providing continuing education to pregnant adolescents and young mothers to permit them to complete high school. We are concerned that providing funds through this legislation without some controls may be used to permit the public educational systems from assuming an appropriate active role.

Given this situation, we would like the Secretary of DHEW and the Assistant Secretary for Education to begin to exert some pressure on State Education Commissioners throughout the country to develop appropriate curricula at all grade levels, and to provide incentives for school districts to develop adequate programing.

In New York we view the problems of adolescent pregnancy as requiring a comprehensive strategy for the development of care and services to pregnant adolescents and young mothers, as well as an implementation plan for preventive programs.

We commend the administration and this committee for evidencing concern about the issue. We believe that with certain modifications, S. 2910 can be a major impetus for programmatic change.

The CHAIRMAN. Thank you very much, Commissioner Blum, that was an excellent statement.

You say your State report is now available?

Ms. BLUM. Yes. There are copies available.

The CHAIRMAN. After we have all of your presentations, we will deal with some of the problems and difficulties of linking this legislation and its program effort to education. From the Federal perspective I think it would be useful to look toward community centers to associate with the community a place where a variety of services can be provided for a multitude of purposes.

Ms. BLUM. I think it is one of the more difficult issues to tackle. Frankly, my concern is that we can continue to develop the other services forever. We have got to begin to reach the earlier ages.

[The prepared statement of Ms. Blum follows:]

TESTIMONY OF BARBARA B. BLUM,

COMMISSIONER OF THE NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES,

CONCERNING SENATE 2910, THE ADOLESCENT HEALTH,

SERVICES, AND PREGNANCY PREVENTION AND CARE ACT OF 1978,

BEFORE THE SENATE COMMITTEE ON HUMAN RESOURCES

July 12, 1978

Mr. Chairman, Senators, my name is Barbara Blum, and I am Commissioner of the New York State Department of Social Services. It is an honor to have this opportunity to provide testimony concerning S. 2910, the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978.

We in New York State are very concerned about the issue of adolescent pregnancy. We are gratified that President Carter has developed legislation which embodies many of the principles necessary to address this issue, and to have a member of the New York Delegation, Senator Jacob Javits, be a cosponsor of the bill.

Few issues in the State or in our nation are as challenging as the subject of this legislation. The nurturing and rearing of children by parents prepared for such responsibilities must be a national priority. In New York State, the commitment of Governor Hugh L. Carey to respond to the needs of young parents as well as to persons pregnant or at risk of pregnancy is clear.

In New York State, in 1976, there were 1.6 million females between ten and twenty years of age. Among females age fifteen to nineteen, there were 62,000 pregnancies at a rate of 78 per thousand females for that age cohort. These pregnancies resulted in 29,800 live births, with approximately 12,600 children (or 42% of such births) born out-of-wedlock. For females under age fifteen, there were 2,000 pregnancies. 640 children were born to these females, and of these, approximately 80% or 510 children were born out-of-wedlock.

These data are dramatic. Viewing the State as a whole, the rate and number of pregnancies in both these age cohorts has been increasing over the past five years.

As a result of this situation, in January 1978 the Governor directed the State Department of Social Services in concert with other agencies, to ensure that adequate family planning services exist for young females and that appropriate programs are provided for teenagers who are either pregnant or young mothers.

The Department shares the Governor's belief that teenage pregnancy is a complex problem with social, educational, health, and employment implications. Any resolution requires a comprehensive approach to the issues. Not only must care and services be provided to pregnant females and young parents; but those factors which are contributing to the prevalence of teenage pregnancy must also be addressed.

Over the past six months, the Department of Social Services has been working with a variety of State agencies to identify service needs, inventory existing and potential programs and resources, and develop planning and program strategies. In addition, the Department established a Task Force on Teenage Pregnancy composed of over thirty persons outside State government, who have knowledge and experience with issues related to teenage pregnancy. The purpose of the Task Force is to aid the Department in defining systems in the community, identifying service gaps, and developing recommendations for actions to be undertaken at the local, State and federal levels of government.

In addition, the Department invited commissioners of local social service districts to attend a meeting to discuss the problem and related programmatic issues in their particular counties, and based upon their experience and knowledge, to propose recommendations for needed action.

Finally, the Commissioner of the State Department of Social Services has conducted throughout the State a series of public forums at which all interested persons and organizations were invited to testify concerning service needs. At each forum, numerous speakers gave testimony on the topic of teenage pregnancy and provided valuable insights.

As a result of these efforts, the Department has prepared a report which contains data concerning teenage pregnancies in New York State, an analysis of existing programs, and recommendations for developing and expanding needed services and care. The Governor has received the report and supports its recommendations. I would be happy to provide any members of this Committee with a copy of the report.

In our analysis of the factors which contribute to pregnancy at an early age, certain issues must be dealt with openly and honestly. Some females become pregnant because they do not know about, want to use, or have access to contraceptives; some females become pregnant as a means of achieving identity and worth; some females become pregnant because ways to achieve economic independence and employment do not exist -- these are complex factors. Government alone cannot resolve many of these issues. There are, however, certain broad goals which should be the basis for our action.

Teenagers must have the opportunity for independence and self-worth. The education system and social, health, and employment systems programs all must participate to create an environment for independence. These systems and programs must be utilized in a manner to support the family both to teach values and to function as a supportive system throughout life.

Broad goals such as these require that social, health, educational, and employment services be available to teenagers who become pregnant. Policies and programs cannot be solely reactive in nature; the need for preventive services and care is evident. A continuum and diversity of programs is required. Programs must be more effective and accessible, and additional services and care must be developed and expanded.

Therefore, the Department views the problem from a four-faceted perspective. This encompasses providing care and services to the existing population of both pregnant females and young mothers to minimize their dependency, and beginning to reduce the prevalence of teenage pregnancy through prevention.

More specifically, the program strategy must include:

* primary prevention which involves the education of young children concerning the importance of human relationships and the responsibilities of family life.

There is an overriding need to educate young children, adolescents, and teenagers concerning the importance of human relationships and the responsibilities of family life. This includes development of self-esteem, self-knowledge, decision-making skills, interpersonal skills, sex education, and parenting skills.

Such an educational process should be a continuous one from infancy through young adulthood, and should be the responsibility of parents, the formal educational system and other institutions and groups which are significant in a child's development — the church, youth organizations, etc.

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* secondary prevention which includes services and counseling for young adolescents and others to enable/encourage informed choice about sexual activity and contraceptives.

Family planning services must be available and accessible to adolescents. The most appropriate locations for such services may vary by locality and may include: family planning clinics, neighborhood health centers, school health services, youth centers, college health centers, private physicians, etc. But the important factor is to be sure that such services are available where teenagers actually "hang out".

In addition, other services must be available and accessible as a preventive measure: educational services, and employment/job training counseling and services.

* services and care for pregnant adolescents and others:

A pregnant adolescent must be provided with information about all alternatives regarding the pregnancy and the necessary care and services. Early determination of the pregnancy is essential. For adolescents who chose to terminate pregnancy, early services and counseling should be made available so as to minimize the risk of late intervention and to ensure that subsequent unwanted pregnancies do not occur. For those choosing to continue pregnancy, early prenatal care should be made available. In addition, services and care must be provided to minimize long-term dependency. To the degree possible, such services and counseling should incorporate the needs and emotional support of the father and the family.

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* services and care for young parents and their families. Services and care should seek to minimize long-term dependence, and to the degree possible, should recognize the responsibility of the father and the family. Such services must be accessible to the client in a manner which will encourage and permit continuing education and/or employment.

From this context, we believe that the proposed federal legislation provides a meaningful first step to address the problem of adolescent pregnancy. The bill views the problem from both a preventive and remedial perspective by providing funds for a variety of care and services. Secondly, the bill permits flexibility with the types of services which may be funded. Funds would be available to ensure linkage among services, and for an all too often forgotten element -- training. Finally, the bill does not place specific eligibility requirements for needed care and services.

In New York, we believe these principles provide an appropriate basis for a sound program strategy. To deal with the teenage pregnancy issue comprehensively, care and services must be made available to adolescents who choose to become parents. The major emphasis, however, must be on prevention if we are to change the current situation.

Second, a variety of care and services must be available and these will vary from locality to locality. In some communities in New York State, there are numerous programs operated by private non-profit agencies such as settlement houses, youth centers and neighborhood centers which currently are a major source of services. In these situations, there is a need to build upon such services and service delivery systems and ensure coordination and access. In other communities, there are minimal services, and the

issue is not service expansion, but service development. This bill would address the needs of both situations. Also, the bill stresses the importance of access and linkage among services which are essential. Assuring access is particularly important in rural areas where transportation is not readily available. In addition, program coordination and case management are all too often lacking, so that many service providers are not aware of other available services.

Finally, it must be recognized that the problem of adolescent pregnancy exists in all communities, and is not limited to those persons receiving public assistance. Increased sexual activity is common among adolescents of all income levels. For example, based upon the number of births for the past several years, it can be estimated that there are currently 94,000 children of parents under age twenty. However, a survey of AFDC cases in March 1977 indicates approximately 15,000 children in public assistance households with mothers twenty years of age or younger. Although this is a low estimate because of the lack of data on combined households, the figure does suggest that a large proportion of teenage parents are not public assistance recipients. The legislation would address this issue by not establishing income eligibility requirements.

At the same time, there are aspects of the proposed legislation which we believe must be strengthened if this legislation is to have a fundamental and constructive impact upon the problem of adolescent pregnancy.

First, there is the issue of planning and coordination. The bill would permit any State, local or private non-profit agency to apply for funds to provide and/or ensure linkage of care and ser . A fundamental problem in New York State has been the lack of program ng and coordination among State agencies and between local, state and federal programs.

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Wherever the funds associated with this legislation are channeled, there must be a requirement for broad, comprehensive community-based program planning and coordination as a prerequisite. We do not need one more source of funds which is administered in a manner uncoordinated from other programs, or is not based upon sound planning.

We believe the best way to ensure sound planning and resource allocation is through grants to the States, with requirements for statewide, community-based planning, and criteria for funding allocations and program accountability.

If federal grants are allocated directly to local providers, there will continue to be a tendency for areas which have minimal expertise and yet a critical need, to receive no funds. For example, in New York State, the counties with among the highest rates of pregnancies and live births and the greatest increases in those rates are the more rural and semi-rural counties.

This approach of direct funding of local organizations exacerbates planning difficulties when funds also flow to the localities from various State and local private sources as well. The greater the number of sources of funds, the greater the probability of no coordination.

An example of these issues, is the use of federal and state family planning funds in New York State. Excluding Medicaid, over $10 million is spent, with about half provided by direct federal Title X grants to local agencies. These providers are predominantly in the more urban areas. The major conduit of the remainder of the family planning funds is through the State Health Department. Yet the Department has had limited success in developing joint

planning and coordination with HEW as to how best to utilize all these funds.

We, therefore, believe that funds should be allocated to the states with strict criteria for planning and coordination. We in New York are beginning such a Statewide planning effort. We have already acquired substantial statistics on a county-by-county basis. In the next several months, we will begin a county-by-county survey of existing programs among both public and private sources. And we are beginning efforts to allocate funds among the many programs, based upon the severity of the problem in localities and in a coordinated manner among agencies. We believe this is the approach which should be utilized to address the critical issues associated with adolescent pregnancy.

Besides the issue of coordination and planning, we believe that there should be a greater degree of flexibility in how the funds are utilized. The legislation would require that no more than fifty percent of funds be utilized for care and services. The bill would not permit funds to be used for services and care which can be funded from other sources.

It is important to stress that needs vary from locality to locality. Certainly, all communities require expanded or developed services and improved access and linkage among such services. But it is inappropriate to suggest limits on how funds should be utilized. It would be more appropriate to require that all proposals incorporate services, linkages, and planning functions or proof that one or more of such functions does not require additional funding. To impose requirements on how the funds must be used does not take into consideration the varying needs among localities.

The bill also appears to place a low priority on funding certain supportive services. Specifically, the bill does not discuss services associated with helping to make persons effective parents. We would argue that parent effectiveness programs are critical as an element of any program for young parents as well as any preventive program. Secondly, the bill excludes infant day care, and employment programs. Infant day care is an important supportive service which can permit teenage mothers to continue their education and acquire employment. Job training, counseling and employment are critical to minimize long-term dependency.

It is true that there are other funding sources to provide those services. But we would argue that the employment programs such as CETA and the Youth Employment Training Act do not provide for or do not provide a sufficient amount of the types of supportive services necessary to acquire and maintain a job.

With regard to infant day care, it is agreed that such program costs should be funded through Title XX. However, you are well aware of the limited funds available in the program and the increasing demands for services at the local level.

Other relevant funding programs should be utilized to the degree possible, but it is inappropriate to suggest that certain services cannot be funded through S. 2910.

The legislation also does not address the problem of public awareness. Increased sexual activity is common among adolescents of all income levels. In New York State, there continues to prevail a lack of community awareness of or willingness to recognize the problem, and I am sure this is not unique to New York. Any program strategy must begin with

stimulating community awareness, for without community support, an effective response to the problem is not possible. Proper use of the media is crucial to creating public interest and understanding. We would recommend that S. 2910 permit funds to be used for this purpose.

Finally, while the legislation recognized the importance of prevention, and the need for adequate services and counseling for young adolescents to enable informed choice about sexual activity and contraceptives, we believe that true prevention must also start much earlier. We must begin educating young children about the importance of human relationships and the responsibilities of family life. As we noted earlier, such an educational process should be a continuous one from infancy through young adulthood, and should be the responsibility of parents, the school system and others. The educational system has a major role to play, and this should be recognized and stressed. We say this for two reasons. In New York, there is a wide variation among school districts as to what is taught, or more properly, what is permitted to be taught. This is a product of both community hesitancy and an unwillingness by the educational profession to assume some degree of responsibility. And certainly this situation is not unique to New York State.

For this reason, we believe that any legislation should require school districts to assume their rightful programmatic role, both in terms of prevention and in terms of providing continuing education to pregnant adolescents and young mothers, so that they may complete high school. We would be concerned that providing such funds through this legislation without some controls would continue to permit the public educational systems from assuming their appropriate role. Given this

situation, we would like to see the Secretary of HEW and the Assistant Secretary for Education begin to exert some pressure on State Education Commissioners throughout the country to develop appropriate curricula at all grade levels and to provide incentives for school districts to develop adequate programming.

In New York we view the problem of adolescent pregnancy as requiring a comprehensive strategy of both care and services to pregnant adolescents and young mothers as well as preventive programs. This requires a coordinated approach at all levels of government. We commend the Administration and this committee for beginning to address the issue. And we believe with certain modifications, S. 2910 can be a major impetus for programmatic change.

The CHAIRMAN. Ms. Blanchard?

Ms. BLANCHARD. Good morning.

I am Mary Lou Blanchard, director of family services, Michigan Department of Social Services.

Educators, social workers and health professionals in Michigan recognize the problems associated with adolescent pregnancy as stated in Senate Bill 2910, and concur that there is a need to make available comprehensive and coordinated services.

Of equal concern are the children of adolescent parents. The infant may be the innocent victim of the adolescent parent's vulnerability and inexperience. The child's chances of falling into the same situation 15 years hence are high because the phenomenon of early pregnancy and early parenthood is often cyclical. Based on that consideration, services intended to break the cycle must be addressed to the children as well as their school age parents.

Studies conducted in New Haven, Baltimore, and Washington, D.C., have shown that early parental care, counseling, social services, and continuing education are effective in reducing school dropouts among pregnant persons, as well as reducing infant mortality and morbidity. Where services to the teenage parent continue beyond delivery of the child, there is a great reduction in the number of subsequent births to these students served and more of the students complete school, and school completion correlates with higher levels of economic independence. The savings which ultimately result from comprehensive services are undeniable in the light of such data.

In response to these concerns, John Porter, Superintendent of Public Instruction in Michigan, convened a school age parenting task force which prepared the first drafts of a model of comprehensive service. This group explained the rationale for, and outlined the essential components of a model program. Their recommendations led to the establishment of an interagency committee involving the directors and staff of the Michigan Departments of Education, Public Health, Mental Health, and Social Services. An interagency policy statement was formulated and signed by the directors of these four State departments. This statement agreed to support interagency planning, collaborative use of existing programs, locally based programs, and interagency responsibility.

As the interagency work proceeded, the committee became formalized as he Interagency Committee for Services to High Risk Children and Their Families, and hired staff with funding from a capacity building grant—to improve coordination of services to young children—from the Administration for Children, Youth, and Families. U.S. DHEW.

This committee developed a comprehensive and integrated model of services for pregnant adolescents, school age parents and their families. This model is available with the testimony.

This model proposed a program which will serve not only the pregnant adolescents, but also the school age parents and their children. The model recognizes the problems are so broad and so complex, that remedial attempts demand interagency cooperation.

Services to the adolescent mother include an educational component that may be provided in an alternative or conventional school setting.

In addition to the full range of academic offerings, this component will include vocational/career counseling.

Health services include instruction in good health and child development, information on family planning and contraception, nutrition, pre and postnatal care, the birth process, the effects of drugs on the mother and fetus, and prevention and treatment of venereal disease.

Social services and mental health services will provide counseling and treatment in problem solving, goal setting, positive self-concept, and the parent-child interaction.

Services to the child will include an onsite day care center and will enable the parent to attend school; facilitate normal growth and development of the child and encourage parent-child interaction and attachment.

Services will also be offered to the father and extended family. The model also includes a component on teaching responsible sexuality.

Implementation of this model will be mandated in each intermediate school district through the State of Michigan in accordance with the State Department of Education's policies and procedures.

Stable funding for implementing the program is the goal. Lack of stable funding up to now has been a serious obstacle. The directors of the four State agencies are working toward a decision as to the best approach for funding. The options are a joint budget request to the Legislature or requests for separate service components made by each individual department. The funding base finally approved will be administered through the department of education and made available to the school districts, and in support of interagency services agreements, for the four State agencies responsible for providing services.

Planning takes advantage of already existing systems, staff, and funding resources. Day care costs for all Title XX eligible children are met through normal State payment procedures. Already existing educational resources such as buildings and administrative staff are utilized. Existing public health and mental health services are coordinated into a comprehensive service delivery system.

Even with interagency coordination and use of existing resources, it is an expensive program. Identified cost to expand the services to cover all persons in Michigan needing services is $4,300,000. All of this is State money. This provides service to 5,000 students per year.

One of the primary barriers to implementing this model is the cost and the funding resources.

Funding could be facilitated if more Federal money was available in already existing programs. Michigan has exceeded its ceiling on Title XX funds. Expansion of services to Title XX eligible persons has to be 100 percent State funds. Increasing the ceiling on Title XX funds available to States would enable expansion of services at a more favorable Federal match, and would facilitate statewide services to high-risk youth.

Title XX regulations could be changed to permit group eligibility for this target group. The budget proposal of $4,300,000 includes $1,650,000 for day care and social services to persons who are not eligible for Title XX services on an individual basis but could be covered on a group eligibility.

The original determination and redetermination of eligibility on an individual basis is a barrier to the students, and thus to the program, and adds to the administrative costs. This is particularly true in the day care component where there is a frequent pattern of absenteeism. Group eligibility would ameliorate this problem.

Michigan has developed and is taking steps to implement a comprehensive model for pregnant adolescents and teenage parents. It is projected that this program will reach 5,000 adolescent women per year. The Alan Guttmacher Institute estimates that Michigan has 187,640 women age 15 to 19 at risk of unintended pregnancy.

Programs need to be developed, grants awarded, and long-term funding assured for comprehensive and coordinated services to sexually active teenagers to prevent pregnancy and improve social and economic independence for them.

Research has shown that 80 percent of those teenagers who have an unwanted pregnancy are not using any method of preventing pregnancy. If unintended premarital pregnancies are to be reduced, serious attention to improved education regarding sexual behavior is needed. It seems necessary to increase the proportion who use contraception and who use it consistently.

This requires increased availability and accessibility to birth control methods through clinics with aggressive outreach to adolescents, and information and services particularly suited to their needs. They need better information about pregnancy risk, in a form that teenagers can absorb, and will believe; perhaps through nonthreatening neighborhood peer networks. Family physicians could be helped to better understand the fertility control needs of their teenage patients.

Programs also need to be developed to provide realistic human sexuality education. This education effort could be provided through schools, churches, youth agencies, and the media. It should offer youngsters, including men, honest and pertinent information about fertility regulation, sexuality, human reproduction, value clarification, and responsible decisionmaking. Educational programs are also needed for parents so they can better understand their children's needs and how they can help them.

Programs for community-based, comprehensive and coordinated services to prevent initial and repeat pregnancies among adolescents, to provide services to pregnant teenagers, and services to school age parents are expensive. Grants to develop these programs and money to evaluate them are necessary. However, it is also necessary to establish long-term funding capabilities to maintain these programs. Adolescent pregnancy, and the subsequent cost in social and economic failures among youth, is a problem our Nation can no longer afford to ignore. We urge speedy passage of this bill.

Thank you.

[The prepared statement of Ms. Blanchard follows:]

TESTIMONY OF

MARY LOU BLANCHARD
DIRECTOR OF FAMILY SERVICES
MICHIGAN DEPARTMENT OF SOCIAL SERVICES

BEFORE THE
COMMITTEE ON HUMAN RESOURCES
OF THE
U.S. SENATE, WASHINGTON D.C.

JULY 12, 1978

Educators, social workers, and health professionals in Michigan recognize the problems associated with adolescent pregnancy as stated in Senate Bill 2910 and concur that there is a need to make available comprehensive and coordinated services.

Of equal concern are the children of adolescent parents. The infant may be the innocent victim of the adolescent parent's vulnerability and inexperience. The child's chances of falling into the same situation fifteen years hence are high because the phenomenon of early pregnancy and early parenthood is often cyclical. Based on that consideration, services intended to break the cycle must be addressed to the children as well as their school age parents.

Studies conducted in New Haven, Baltimore, and Washington D.C. have shown that early prenatal care, counseling, social services, and continuing education are effective in reducing school dropouts among pregnant persons, as well as reducing infant mortality and morbidity. Where services to the teenage parent continue beyond delivery of the child, there is a great reduction in the number of subsequent births to these students served and more of the students complete school, and school completion correlates with higher levels of economic independence. The savings which ultimately result from comprehensive services are undeniable in the light of such data.

In response to these concerns, Dr. John Porter, Superintendent of Public Instruction in Michigan, convened a School Age Parenting Task Force which prepared the first drafts of a model of comprehensive service. This group explained the rationale for and outlined the essential components of a model program. Their recommendations led to the establishment of an Inter-Agency Committee involving the Directors and staff of the Michigan Departments of Education, Public Health, Mental Health, and Social Services. An Inter-Agency Policy Statement was formulated and signed by the Directors of these four State departments. This statement agreed to support inter-agency planning, collaborative use of existing programs, locally based programs, and inter-agency responsibility.

As the inter-agency work proceeded, the committee became formalized as the Inter-Agency Committee for Services to High Risk Children and Their Families, and hired staff with funding from a capacity-building grant (to improve coordination of services to young children) from the Administration for Children, Youth and Families, U.S. DHEW.

This committee developed a Comprehensive and Integrated Model of Services for Pregnant Adolescents, School Age Parents and Their Families. This model proposed a program which will serve not only the pregnant adolescents, but also the school age parents and their children. The model recognizes the problems are so broad and so complex that remedial attempts demand inter-agency cooperation.

Services to the adolescent mother include an educational component that may be provided in an alternate or conventional school setting. In addition to the full

range of academic offerings, this component will include vocational/career counseling.

Health services include instruction in good health and child development, information on family planning and contraception, nutrition, pre and postnatal care, the birth process, the effects of drugs on the mother and fetus, and prevention and treatment of venereal disease.

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1. The Alan Guttmacher Institute, Contraceptive Services for Adolescents, United States, Each State and County, 1975. 1978 Table 1, pg. 82.

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A COMPREHENSIVE AND INTEGRATED MODEL OF SERVICES FOR PREGNANT ADOLESCENTS, SCHOOL-AGE PARENTS AND THEIR FAMILIES IN THE STATE OF MICHIGAN

TABLE OF CONTENTS

Prepared by the School-Age Parenting Task Force
and the
Inter-Agency Committee for Services to
High Risk Children and Their Families

I. INTRODUCTION

Educators, social workers and health professionals are increasingly concerned about the problems associated with early and unplanned pregnancy. Some 9,000 adolescent girls and their partners in Michigan, still of an age to be enrolled in school, annually face the decisions and consequences of pregnancy and premature parenthood. Interrupted schooling, health problems, precipitous marriage and equally precipitous divorce, single parenthood and welfare dependency are a repetitive pattern.

Of equal concern are the children of adolescent parents. The infant may be the innocent victim of the adolescent parent's vulnerability and inexperience. The child's chances of falling into the same situation fifteen years hence are high because the phenomenon of early pregnancy and early parenthood is often cyclical. Based on that consideration, services intended to break the cycle must be addressed to the children as well as their school-age parents.

Studies conducted in New Haven, Baltimore, and Washington D.C. have shown that early prenatal care, counseling, social services and continuing education are effective in reducing school dropouts among pregnant persons, as well as reducing infant mortality and morbidity. Where services continue beyond delivery, there is a great reduction in the number of subsequent births to the students served and school completion correlates with economic independence. The savings which ultimately result from comprehensive services are undeniable in the light of such data.

In the past decade some 60 school districts in Michigan have established educational programs for pregnant students. A number have developed comprehensive services for the pregnant student; fewer - because of fiscal contraints - have extended their programming to the adolescent parent and to her child.

In 1975, in response to these concerns, Dr. John Porter, Superintendent of Public Instruction, convened a School-Age Parenting Task Force which prepared the first drafts of a model of comprehensive service. This group did an excellent job of explaining the rationale for and outlining the essential components of a model program. Their recommendations led to the establishment of an Inter-Agency Committee involving the heads and staff of the Michigan Departments of Education, Public Health, Mental Health, and Social Services. In the spring of 1977, the head of the Michigan Community Coordinated Child Care Council, representing the Department of Management & Budget, joined the committee. As the inter-agency work proceeded, the committee became formalized as the Inter-Agency Committee for Services to High Risk Children and Their Families.

This model of comprehensive and integrated services proposes a program which will serve not only the pregnant adolescents but also the school age parents and their children. The model recognizes that the problems of school age pregnancy and early parenthood are so broad and so complex that remedial attempts demand inter-agency cooperation. However, educators must understand that their position is unique in respect to this problem. No other state institution has comparable access to these young people in terms of frequency or duration. No other institution has as great a potential for preventive action as does the public school system. Therefore, public education must address itself to the special problems of boys and girls who find themselves faced with the difficult task of parenting.

The model outlines the services expected of public education and the linkages with other agencies.

The model presents a comprehensive program in two settings: the alternative education program and the conventional school. The two options enable local or intermediate school districts to develop a program that best meets their needs. The alternative education program is flexible and individualized and geared to those who might have difficulty staying in a regular school program and coping with the demands of pregnancy and motherhood.

The conventional school program requires that the adolescent takes the responsibility for her own academic program and must meet the demands of a conventional schedule; however, special services related to pregnancy and parenthood would be provided.

Section III describes these programs for the pregnant adolescent and school-age mother. The needs of the children of school-age parents are addressed in Sections IV; the goal is to serve the child through the teenage parent in order to improve the quality of life for both. Sections V and VI are concerned with services to the teenage father and the extended family; these, too, are essential elements of a comprehensive and integrated program. To meet the needs of parents who have dropped out of school, the model also proposes outreach services (Section VII).

The final section, Teaching Responsible Sexuality, proposes a plan for reaching the entire school-age population by implementing state guidelines and calling for community cooperation in family life and human sexuality education.

POSITION STATEMENTS

1. School-age parents and their children are a high risk population of concern to State government, and specifically the Departments of Education, Public Health, Mental Health, Social Services and Management & Budget.

2. To meet the needs of this population, comprehensive services are required for both the adolescent and the child of the adolescent. Parent and child should receive simultaneous and inter-related services.

3. Comprehensive programs for school-age parents and their children must be a stable and organized part of the school program.

4. Funding of comprehensive services for school-age parents and their children should be provided in a manner least burdensome to the localities.

5. Local education agencies should provide a multi-disciplinary program to develop positive parenting skills and to improve the quality of the child-parent relationship.

6. Intervention should occur as early as possible during pregnancy or in the early life of the child. The earlier the intervention, the greater the likelihood of successfully enhancing parenting patterns.

7. An effective health education curriculum (K-12) must be implemented to break the cycle of school-age parenthood. The curriculum, including the physical, emotional, intellectual and social aspects, should focus on the information and skills students need to make decisions, assume responsibility for their own actions and build a positive self-concept.

8. The state departments involved (#1 above) should develop evaluation criteria for the programs in the areas of a) Parent growth; b) Infant growth; c) Parent-infant interaction; d) Program effectiveness.

II. PROGRAM GOALS AND IMPLEMENTATION

A. Goals

The program goals of the comprehensive and integrated model of services for pregnant adolescents, school-age parents and their families are:

1. To meet the complex needs of pregnant adolescents and young parents and their children.
2. To decrease the incidence of dropouts among pregnant adolescents and school-age parents through a comprehensive program of education, health, mental health and social services.
3. To prevent repeat pregnancies in the adolescent years.
4. To prevent the cycle of premature parenthood and aberrant parenting.

The goals for individuals participating in the program are:

5. Each pregnant student and young mother will freely choose whether to give up or keep her baby after receiving information and counseling and follow-up counseling appropriate to her choice.
6. Each student will grow personally and socially and continue to develop a positive self-concept.
7. Each student will acquire knowledge and skills which will enable her to become economically self sufficient.
8. Each school-age parent will, with support, develop the attachment to the infant, nurturing skills and knowledge which will enable her to succeed in the parental role.
9. The young mother, with a flexible adademic program, will work with and spend time with her child each day.
10. The child will develop his or her potential through experiences addressing physical, emotional, intellectual and social development.
11. The teenage father will have access to support services so that he may complete his education, participate in education for parenthood and participate in family decision-making.

While the model program focuses upon comprehensive and integrated services, prevention is also a long term goal. One goal of an effective K-12 health education curriculum is to prevent unwanted and early pregnancies, especially of young women under 18 who have not completed high school.

B. Implementation

The implementation of this model for services to pregnant adolescents and young parents and their children will be mandated in each intermediate school district throughout the State of Michigan in accordance with rules promulgated by the State Board of Education. The Intermediate School District may implement the model or may arrange for one or more local districts to provide services. The ISD shall be responsible for assuring access to service for residents of all constituent districts.

1. Administration of Program

a. The State Department of Education shall review and approve alternative education programs under Section 93 (or 48, as proposed) of the School Code of 1976.

b. The State Department of Education shall appoint a full-time consultant with responsiblity for school-age parent programs and the inter-agency coordination related to such programs.

c. The Board of Education of the Intermediate School District operating a program shall have responsibility for the operation and administration of the program.

d. Each school district operating a program shall designate an administrator who will be accountable for establishing procedures for the education and enrollment of students and for the coordination of services to pregnant adolescents and school-age parents.

e. Each school district operating a program shall have a community council serving in an advisory capacity and composed of not less than thirteen representatives from the following:

- Department of Public Health -- Nurse
- Community Mental Health Agency -- Infant Intervention Specialist
- Department of Social Services
- Two students or teenage parents
- Two extended family members
- Cooperative Extension Agent -- Child Development
- School Board Member or upper level school administrator
- Juvenile Court
- One local Community Coordinated Child Care Council (4C) representative

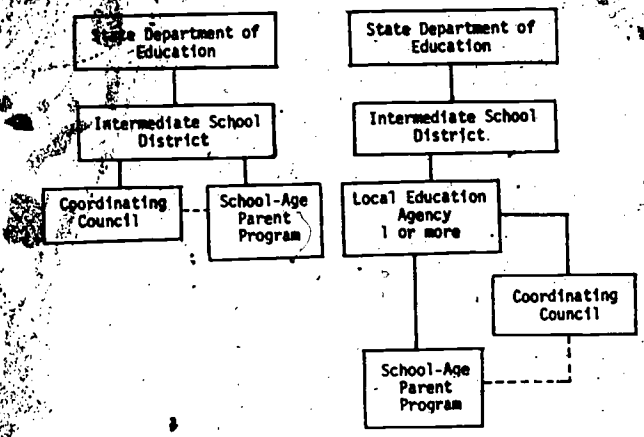
- Physician (preferably an obstetrician or family planning physician)
- One representative of the community-at-large (two if there is no local AC)
- Ex officio, local/intermediate school district School-Age Parent Program Director.

Each agency shall recommend its own representatives to the coordinating council. The Board of Education shall appoint council members representing a broad community approach to meeting the needs of pregnant adolescents and school-age parents.

f. The coordinating council will report to the Board of Education, not less than annually, and will have the following functions:

- Assist in identifying service needs through review and study;
- Review the implementation of program goals;
- Submit program recommendations to school officials;
- Assist in the coordination of community resources;
- Provide a forum for School-Age Parent concerns;
- Act as an advocate for the program and its recipients;
- Receive program evaluation data.

g. The Intermediate Districts have the option of implementing this model or arranging for one or more local districts to provide services.



2. Program Responsibilities

a. Each school district operating a program shall provide either an alternative program and/or a program within the conventional school.

b. Program components shall include:

- provisions for counseling students concerning pregnancy outcome and alternatives;
- education, health and social services for pregnant students;
- health and social services for teenage parents;
- parenting education for the pregnant teenager and teenage parent;
- child care and child development programming for the child of the teenage parent, for as long as the teenage parent is enrolled in school;
- outreach to the extended family and to the child's father.

c. The School district may also provide outreach services to drop-out parents and their children.

d. Each school district operating a program shall make arrangements for supportive services through:

- The utilization of approved school social workers and certified school nurses and/or
- Agreements with the County or District Department of Public Health and the Community Mental Health Agency and social service agencies.

e. Each school district operating a program shall require the program director, with the aid of the coordinating council, to prepare an annual report of:

- number of students served in the program*
- number of infants served in the program
- number of program participants who graduated*
- number of program participants who returned to regular school program*
- number of students returning to special programming
- number of students lost to program (drop-out, moved, unknown cause)
- number of students who spent

3 months	15 months
6 months	18 months
9 months	21 months
12 months	24 months in program

- number of girls in program who are:

i) repeat pregnancies
ii) repeat pregnancies and were enrolled in program before

*Currently required in "Report of Accredited Alternative Program for Pregnant Students," Michigan Department of Education

The report shall go to the ISD and State Department of Education

Funding

a. Funding for the pregnant students/school-age parent programs allocated by the legislature to the Michigan Department of Education shall be distributed to local and Intermediate Districts operating approved programs. Funds shall be disbursed for education, health, social services and mental health components according to the following formula:

- Education: The district operating the program shall receive an amount per pupil equal to the approved cost per full-time equated pupil minus the gross membership allowance per pupil. The reimbursement shall not exceed $600 per full-time equated pupil in a program in an alternative setting.

  Programs in a conventional school setting shall be reimbursed a maximum of $300 per full-time equated pupil.

- Social Services: Approved cost of counseling, information and referral services up to 75% of the approved budget not to exceed $425 per pupil.

- Health: Approved cost of health counseling and health care services as defined in pages 12-13 up to 75% of the approved budget not to exceed $130 per pupil.

b. Funding and Implementation of the Program for the Children of School-Age Parents.

- The school district providing a program for pregnant teenagers and school-age parents shall make available a space in the child care center for each school-age parent who is enrolled in an approved school program leading toward high school completion and who needs a child care program.

- When a program is too small to support a day care center, the school district and the school-age parent may designate a licensed family or group day care home to provide child care. The school district will have the responsibility for assuring the provision of comprehensive services. The district operating the school-age parent program shall also provide a regularly scheduled parent education program, for parent and child together (see pages 17-19).

- Programs for the children of school-age parents will be administered by the Intermediate School District in conjunction with the program for the parents. Funds will be distributed by the Michigan Department of Education to the district operating the program for comprehensive services (pages 18-21) according to the following formula:

  i) For each child whose parents are not eligible for reimbursement for day care services under Title XX and who is in a designated child care program, the district will be reimbursed a base amount equal to the Department of Social Services authorized rate for that age group.

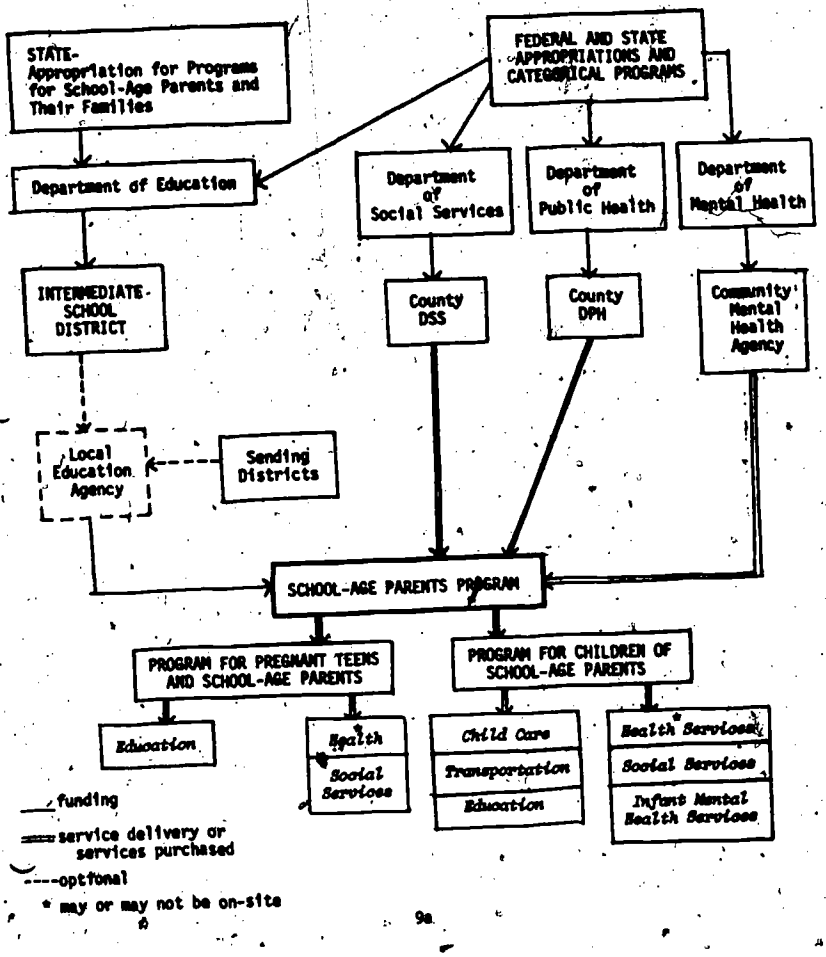
  ii) In addition, the district will receive funding on a 75% state/25% local match basis not to exceed a total state reimbursement of:

  - Education: $60 per child to cover costs of the educational program;
  - Health: $50 per child to cover the costs of health care counseling and services;
  - Social Services: $60 per child to cover the costs of counseling, information and referral services.

  iii) On a 90% state/10% local match basis, each program will be reimbursed up to $6300 State funding to cover the costs of the Mental Health component.

  iv) For each child whose parents are not eligible for reimbursement for day care transportation costs, the district will be reimbursed for costs of transportation an amount not to exceed the authorized Department of Social Services rate for such services.

PROPOSED FUNDING OF AND
DELIVERY OF SERVICES TO PROGRAMS FOR
SCHOOL-AGE PARENTS AND THEIR CHILDREN



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III. Services to the Adolescent Mother

Education, health, mental health and social services will be planned and coordinated by the agencies involved. The overall program goals are set forth above (II, A). This section of the model specifies objectives for each component of the program and describes alternative delivery systems.

A. Education

1. Structure of Program

The educational component may be in an alternative or conventional school setting. It will provide a full range of academic offerings and services to meet the special needs of the pregnant adolescent and the school-age mother. Staff for the educational program must be a corps of professionals and paraprofessionals selected for such personal qualities as empathy, caring, nonjudgemental and flexible attitudes, ability to work with adolescents and capacity to serve as role models.

a. Alternative School Setting

The educational program in this setting will provide for all students (without unnecessary interruption) access to a full scope of curricular offerings equal to those offered in the conventional school program, plus special programming related to their particular needs as prospective or actual parents. Students will participate in a program adapted to individual capabilities, interests and needs based on short-term, realistic goals. The alternative education program is designed to allow the flexibility often needed for young mothers to be successful in school and in child-rearing.

b. Conventional School Setting

The special tasks of the program in the conventional school setting will be:

- To develop an individualized and flexible program for each student enrolled;
- To provide a liaison and a system of open communication between those staff members responsible for the academic program and those responsible for the specialized services and programming to assure adequate planning for each student;
- To provide special programming related to their particular needs as prospective parents and parents.

2. Objectives
   a. Students will attend school regularly, i.e., at least 75% of enrolled days.
   b. Students will demonstrate academic growth and progress in courses meeting requirements for graduation, as measured by appropriate: standardized tests, objective referenced instruments, teacher observation and academic records.
   c. Students will participate in vocational/career counseling, planning and preparation and may also gain work experience. Progress will be evaluated by the completion of a plan outlining a vocational choice or up to three alternatives.
   d. The pregnant student will demonstrate through oral or written report, examination or discussion, knowledge of
      - Good nutrition during the prenatal and postpartum periods;
      - Prenatal and postpartum changes in the mother's body-including warning signs;
      - Health care in the prenatal and postpartum periods;
      - The effects of drugs, including alcohol and tobacco, on the mother, the developing fetus and the breast-fed infant;
      - The prevention, symptoms and treatment of venereal diseases;
      - The birth process - from conception through delivery;
      - Family planning concepts;
      - Methods of contraception.

   e. The school-age mother will, in addition:
      i. Demonstrate through oral or written examination or report, knowledge of:
      - Nutrition needs of the lactating mother;
      - Nutrition needs of the infant and child;
      - Growth and development of the infant and young child;
      - Infant and child care
      ii. Demonstrate ability to use skills learned in
         - parenthood education;
         - homemaking and family management.

3. Delivery of Services
   a. Alternative School
      i. Administrative staff will consist of Principal and a secretary;
      ii. Teaching and supportive staff will include
         - Secondary teachers certified in appropriate academic & vocational areas;
         - Teacher(s) qualified as prenatal, parenting and family life and human sexuality educators;
         - Teacher aides or volunteer tutors;
         - Approved social workers;
         - Registered nurse;
         - Home visitors.

b. Conventional school
Administrative staff will consist of
- Coordinator or Assistant Principal
- Secretary
Teaching and supportive staff will include
- Teacher(s) qualified as prenatal, parenting and family life and human sexuality educators
And may also include
- Teacher aides or volunteer tutors
- Approved school social workers
- Certified school nurse/licensed practical nurse
- Home visitors.

c. Support from other agencies
Staff of other community agencies may provide services or supplement services provided by the school staff system. Staff support will include:
- Public health nurse assigned to participate in instruction and make provisions for health care.
- Public health nurses with responsibility for health care and follow-up of adolescent parents.
- Social services worker(s) with responsibility for adolescent parents.
- Infant mental health specialist or other mental health staff.

Continuity of care for the school-age parent should be a guideline for agencies in assigning staff to work with the adolescent parent program. Wherever possible, the adolescent caseload should be grouped so that the task of coordination with school staff is facilitated. Each team working with an adolescent should participate in regular case conferences to insure coordination.

B. Health

Students will receive health counseling and instruction through individual and group meetings and home visits. Students will have the opportunity, in classroom discussions, practical exercises, everyday planning and in the day care center, to apply their knowledge of good health and nutrition for themselves and their children.

1. Objectives
a. Students will demonstrate knowledge of good health practices as specified in III (A) (2) d and e.
b. Students will demonstrate to the professional team member or report on their own health practices, including proper nutrition, exercise and regular check-ups, according to their status as pregnant adolescent or young mother.
c. Students will demonstrate their knowledge of community health resources, including health maintenance and family planning services, and the referral process, by reporting on their own experience or describing a plan for obtaining needed services.

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d. Students will, in working with their own children, apply their knowledge of child development, child care and parenting in a play situation and a stress situation.
e. Students will be able to describe steps in the process of deciding on the use of contraception, applying their knowledge about particular methods and available health resources.

2. Delivery of Services

One team member working with the adolescent should assume responsibility for health education and health care management. That team member might be the school nurse, health educator, Public Health nurse assigned to the program or Public Health nurse with the pregnant adolescent or school-age mother in her caseload.

For each student there should be a health care management plan including:
- health education
- pregnancy testing and counseling
- prenatal care
- preparation for child birth
- family planning
- postpartum care
- health care management plan for the infant.

The girls will receive these services from one or more agencies, such as the Alternative Education program, the health department, local agencies, hospitals and private physicians. The team member with the responsibility for health services will work with the girl in developing the health care management plan and facilitating access to the needed services.

C. Social Services

Students will receive counseling services (both on-going and crisis) through individual and group counseling. If required, students will be referred to outside agencies for specific needs.

1. Objectives

a. Students will demonstrate that they have the knowledge and ability to utilize community resources for:
- Meeting economic needs;
- Planning alternatives for caring for the expected infant;
- Legal rights and responsibilities;
- Transportation to agencies which are providers of special services.

b. Students will be able to demonstrate increased skill in problem-solving and goal-setting in the inter-intra personal domains.
c. By the end of the enrolled period, the student will have participated in developing a follow-up plan of supportive services to be delivered through school-related services or appropriate outside agencies.

2. Delivery of Services

School social workers, counselors or social workers assigned to the school-age parent program will:

a. Facilitate the eligibility assessment for service and provision for enrollment in:
   - AFDC
   - Medicaid
   - Day care support for child;
b. Contact families to:
   - Acquaint family with the program;
   - Provide casework service and personal reinforcement to total family.
c. Provide crisis counseling whenever needed.
d. Provide follow-up counseling service for students
   - who return to their home school;
   - who drop out of school.
e. Coordinate services with other community agencies (e.g. health department, juvenile court, social services, family and children services, mental health).
f. Reinforce parents, grandparents, or parent surrogates and all extended family members for providing a developmentally stimulating and emotionally stable environment for the children.

Mental Health

Mental health objectives will be accomplished primarily through the implementation of the previously outlined objectives in ways which increase the positive self concept and independence of students, develop problem solving skills and the ability to use a range of behaviors, and develop appropriate nurturing behavior. In addition, the mental health needs of the student may be met through:
- Provision of a consistent home visitor who acts as a nonjudgemental supportive advocate;
- Course work which encourages discussions of feelings;
- Group discussions related to mental health needs;
- Individual counseling.

1. Objectives

a. Students will be able to explain the value of formal and informal resources and will have established linkages to on-going peer and agency support systems.

b. Students will demonstrate that they understand the difference between feeling and action.
c. Students will demonstrate knowledge of the contribution of parent-child interaction to the behavioral, affective and cognitive development of the child.
d. The school-age parents will resolve or begin to resolve the emotional or attitudinal impediments to nurturing.
e. The school-age parents will establish a strong attachment to their infants.

2. Mental Health services

a. Training of program staff in:
- empathy and listening skills;
- positive reinforcement techniques;
- assessment and shaping of parent-infant interaction.

b. Provision for consultation from mental health staff.
c. Provision, where, indicated for infant intervention services (where available) and for mental health services.

E. Support services

1. Hot lunch program

2. Transportation
- to school
- to health service agencies
- to social service agencies.

3. Home visits by nurse, social worker, mental health specialist, or home visitor.
- at least one home visit to ascertain home circumstances and to observe parent-child interaction;
- whenever absent from school for an extended period;
- supportive, therapeutic visits as needed. Where circumstances warrant, all agencies should combine forces to schedule frequent home visits.

F. Other services

Temporary residential service for homeless pregnant adolescents, school-age parents and their children.

IV. Services to the Children of School-Age Parents

Children of school-age parents are generally labeled as high risk by medical, social, psychological and educational professionals:

> Research evidence indicates early family life is linked to conception out of wedlock, unstable family life, unfinished secondary and sometimes elementary education, poor health outcomes of mother and infants, divorce, welfare dependency, reduced work potential, and generally unsatisfactory life fulfillment.[1]

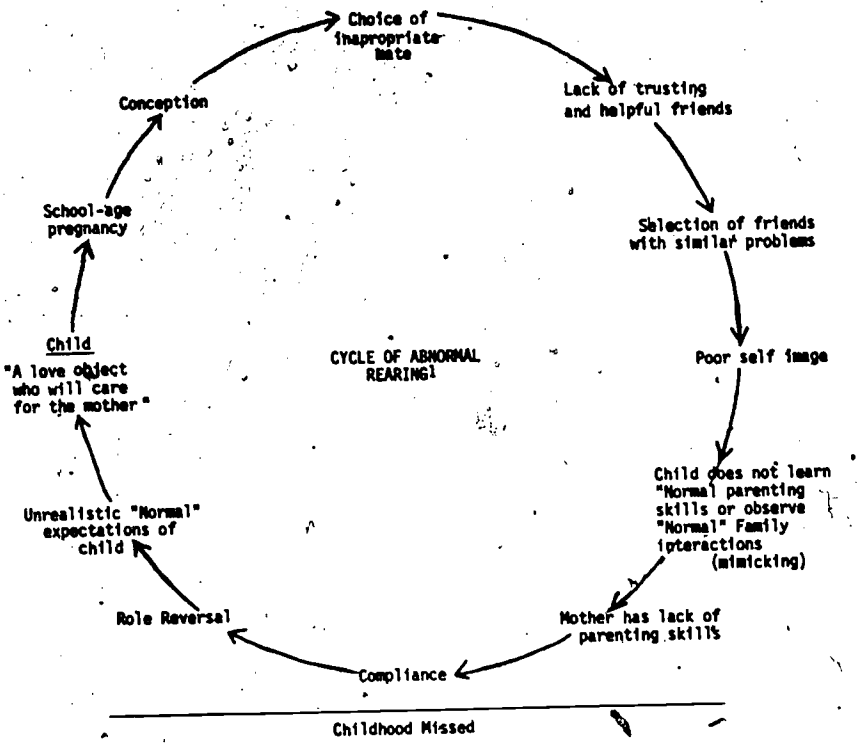
The infants of adolescent mothers, particularly those living in poverty, who survive the high risks of the pre-natal period and the birth experience without damage to the brain or nervous system, are often engulfed in socio-cultural deprivation. Such deprivation can be an even greater cause of retardation, with malnutrition and probably abuse and neglect added to the staggering risks heaped upon the child.

The school-age parent, in many cases, has not learned to be an effective parent and perpetuates a cycle of abnormal parenting. To break this cycle, a program must utilize all possible resources.

The program for the children of school-age parents is delivered through a child care center attached to the alternative school or conventional school program serving adolescent parents. Such a child care center should be open to all children of adolescents enrolled in school programs leading toward high school completion It provides an inter-disciplinary program of health, education, mental health and social services directed to meet the complex needs of the children, age 0-5, of adolescent parents. Health is an integrated part of the school program. Physical setting, staffing and program go beyond the minimal requirements for licensure of child care centers under Department of Social Services Regulations.[2]

[1] Bernard Braen, Clinical Child Psychology Newsletter, Special Double Issue on Sex, Volume X, Nos. 2 and 3, Summer-Fall, 1971, pp. 17-20.

[2] "Nursery Schools and Day Care Centers: Requirements for Licensure," Michigan Department of Social Services.



A. Personnel

1. Supervision, teaching and child care staff

- Coordinator of early childhood education/certified teacher;
- Supervisor of Child Care Center;
- Caregivers in ratios consistent with Michigan Department of Social Services Regulations.

2. Supportive Service Staff

It is helpful to have the same person assigned to both mother and infant. Staff people who may be shared between the child care and teenage parent programs include:

- Social worker
- Health nurse
- School diagnostician
- Parenting educator
- Home visitor

[1]Adapted from Ray Helfer, "World of Abnormal Rearing", Pediatric Basics, #10, Feb. 1974

B. Child Care/Educational Component

The goals of this child care component are to:

- Enable the parent to attend school,
- Facilitate normal growth and development of the child,
- Encourage healthy parent-child interaction and attachment.

1. Objectives

- Throughout the period of enrollment, the child will evidence age-appropriate developmental behavior in sensory, motor, intellectual and affective areas.
- The parent will demonstrate positive attachment to and active interaction with the child as measured by eye contact; touching; child's responsive smiling; verbal interaction; parent's responsiveness to cues and ability to quiet the child; play behavior.

2. Delivery of services

The child care component will encourage the individual development of each child with appropriate stimulation from birth on for physical, emotional, social and intellectual growth. To be effective it must involve the parent in training and support. The child care component will include:

a. An emotionally stable environment through the assignment of each infant to a specified "primary" caregiver selected for warmth, empathy, maturity, concern and continuity;
b. An environment which offers visual, auditory, motor and tactile stimulation;
c. A structured curriculum with emphasis on the child's development of positive self concept, language and problem solving skills;
d. Personalized and individualized activities daily, in accordance with each child's individual needs and strengths (determined through observation and diagnostic assessment);
e. Enhancement of parenting skills by providing all adolescents enrolled in school programs with
   (a) supervised child care
   (b) group programming with 8-10 mothers and infants together[1]
   (c) in-home programming

   during which staff observes mother-infant interaction and encourages and models positive parenting behavior;
f. Screening of each child's developmental status at stated intervals.

[1] The Infant Stimulation/Mother Training Project", by Earladeen Badger, in Monograph in Infant Education, edited by Bettye Calwell, 1975.

C. Health Component

1. Objectives
To provide for a comprehensive health program which will enable young parents to attain and maintain favorable conditions of health for their children and themselves.

Throughout the period of enrollment the child shall:
a. Attain and maintain favorable health
b. have nutritional needs met.

2. Delivery of services
The health component will include preventive as well as health maintenance services:

a. Consistent daily health practices in the child care setting.

b. Daily reports to parents on child's health.

c. A realistic health program for the child, developed in concert with the mother, and providing for scheduled access to health services.

d. Assistance to the mother in obtaining access to community health services.

e. Provision of transportation to community health services when necessary.

f. Consultation with nurse whenever needed.

g. Home calls by nurse as needed.

h. Experiental and didactic child health education for the mother.

i. Physical examination by a registered nurse or nurse practitioner trained in pediatric assessment.

D. Social Service Component

1. Objectives
To provide for social services available in the community and appropriate to the needs and total well being of the child with particular reference to the avoidance of neglect, abuse or exploitation and to the support and rehabilitation of families.

2. Delivery of services

The social services component includes:

a. Personalized child care plan fitted to individual needs.

b. Individual casework, personal reinforcement and supportive services to children and their school-age parents.

c. Crisis counseling as needed.

d. Home visits.

e. Coordination with other community service agencies (e.g. financial resources, legal representation).

f. Transportation

g. Follow-up service for children after they no longer use center.

E. Mental Health Component

1. Objectives

Mental Health objectives (See III. D. 1. c,d,e.) will be accomplished through a program which encourages the healthy affective development of the child.

2. Delivery of services

Training and consultation with the school-age parent program and child care staff to assure that the program provides:

a. Continuity and stability of the person giving care so that an attachment can be formed and maintained.

b. Consistancy in management between day care center and parent.

c. Warmth, empathy, caring attention to the child and to the mother so that she can nurture the infant.

In addition, special services may be provided by infant mental health specialists attached to community mental health agencies.

V. Services to the Father

The adolescent father has special needs that are similar to those of the mother in many respects, but are also unique. The primary goal is to locate the young-father-to-be and inform him of the support and services that are available to him in a non-threatening environment. Reaching the father is a problem that may be compounded by reluctance to identify himself, by his already having dropped out or by his fears of entanglement. A program for fathers must be community-based and should include male staff. Those programs that have been successfully serving fathers have used outreach, counseling and informal group discussions.

A. Objectives

The school-age father will:

1. Identify a vocational or career goal and outline steps to acheive that goal.
2. Complete his education in accordance with his own vocational goals.
3. Understand his own sexuality - including the difference between sex role and sexual behavior.
4. Understand key family planning concepts.
5. Demonstrate knowledge of:
   - methods of contraception, including advantages and disadvantages, use and availability;
   - the legal rights and obligations and economic responsibilities attached to fatherhood;
   - prevention, symptoms and treatment of venereal disease.
6. Make well-informed decisions (in concert, where possible, with the pregnant teenager and each of their families) about accepting the responsibilities of marriage and fatherhood.
7. Study, with the teenage mother:
   - the development of the young child
   - the needs of the young child
   - parenting skills - including nurturing and enhancing the development of the child.
8. Interact with the child, reflecting positive parenting skills.

B. Delivery of services will include:

1. As a first step, an outreach program to bring the young man into small group discussions regarding
   - sexuality - including human reproduction as well as sex roles and sexual behavior
   - family planning
   - contraceptive methods
   - venereal disease
   - legal rights and obligations of marriage and fatherhood.

2. Individual counseling for discussion of legal and financial rights and obligations to the father to define the responsible options available to him.
3. Counseling services which include the opportunity to work with the young mother and father and their parents.
4. Vocational and educational counseling to develop a career plan and provide support in carrying it out.
5. Prenatal, postpartum and parenting education in the alternative or conventional school setting.

VI. SERVICES TO THE EXTENDED FAMILY OF SCHOOL-AGE PARENTS

Any plan for prevention and service will ideally include the grandparents of the infant and/or other significant persons for it is important to have their understanding. Parents of the adolescent need to become aware of the special physical, social and educational needs of the pregnant teenager, adolescent parent and grandchild. Social workers, nurses and home visitors identified as staff, will work with families through home visits, individual contact on site and group sessions, seeking to:

- Assure a home and family environment conducive to healthy personal growth and maturation for the adolescents and their child;
- Prevent further pregnancies in the adolescent years and to work toward prevention of pregnancies in adolescent siblings and other closely related teenage persons.

1. Objectives

   a. Parents of the adolescent will have knowledge of the experience and needs of the pregnant adolescent and be able to assist her in meeting those needs. They will be informed regarding:
      - changes and needs during the prenatal period, including nutrition; exercise, health care and warning signs.
      - myths and superstitions related to pregnancy.

   b. Parents will have knowledge of the experience of childbirth and be able to provide needed support during labor and delivery and in the postpartum period. They will have knowledge of:
      - Contemporary childbearing practices and preparation for childbirth;
      - Prenatal development;
      - the birth process.

   c. Those who will assist in labor and delivery will participate in preparation for childbirth classes.

   d. Parents will recognize and help the adolescent adjust to the emotional and physical changes occuring in the postpartum period.

   e. Parents will have knowledge of the use of contraception and their responsibility in encouraging the use of birth control.

2. Services

A range of services will be available to the families of the school-age parent, including educational and counseling services, delivered through group meetings, parent interviews and home visits. Such services will provide the families of school-age parents with:

a. A realistic approach to promote better communication between parents and adolescents.
b. Regular group and individual counseling to develop a healthy parent-adolescent relationship.
c. Referral to the appropriate resources to supplement and continue specific on-going services as needed.

VII. OUTREACH SERVICES

The school district may provide outreach services to school-age parents who have dropped out and to their children. One primary outreach task is casefinding - locating those young parents who have not completed school and need information about programs and support services. The other is providing temporary home instruction for those students who have dropped out of school and are in need of support before they can re-enter or who are in transition or preparing for the equivalency or general education test.

A. Objectives

1. Students who have dropped out will know what educational and supportive services are available to them - whether or not they choose to return to the conventional school.

2. Students who choose to return to a school program will keep us with their school program during a short term period of homebound instruction and return successfully and graduate.

3. Students will have access to support services to attain the objectives specified in III, A, B, C, D.

B. Delivery of Services

One team functioning in the alternative education or conventional school program will have the responsibility for coordinating outreach services in the district. The team will set up a process for evaluating the needs of the dropout students, developing a casefinding procedure and for coordinating services to the student in this temporary situation.

Child care and parenting classes as offered through the district's program for school-age parents will be available to those in the outreach program.

VIII. TEACHING RESPONSIBLE SEXUALITY

While the programs in the alternative and conventional school settings address specific needs of the adolescent population, the schools should assume a broader responsibility: to promote a curriculum for all students designed to develop self understanding and healthy interpersonal relationships. The content of such a curriculum should increase in complexity and receive greater emphasis as the child progresses from the preschool years through the period of secondary education. The schools can offer an accurate, comprehensive and consistent approach to understanding human sexuality and reduce the misinformation that prevails among young people. A curriculum that helps students to examine their own attitudes and builds decision-making skills will encourage students to make responsible decisions regarding sexuality.

Local school districts may adopt guidelines issued by the Michigan Department of Education or may establish their own, in cooperation with the Intermediate School District, and county or district department of public health. The law further provides that where a school district offers a course in reproductive health or family planning, a community advisory board will review materials and methods of instruction. Members of the advisory board will include: parents, pupils, educators, clergy and health professionals.

A. Objectives

With the development of community awareness of the need for school programs in health, family life and sex education and planning and implementation of a family life and sex education curriculum that meets local needs:

1. Parents and pupils will set realistic goals and expectations about a health and human sexuality education program.
2. Parents and youth will understand :
   - the processes of growth and development;
   - the needs of young children and adolescents in relation to their own sexuality;
   - human sexuality including psychosexual development and sexual behavior;
   - family planning concepts and methods.
3. Young people will be able to evaluate health information and to make responsible decisions.

B. Implementation

The impetus for local program development might come from several sources within the community. The school board, the health department or other community agency, teachers, pupils or the School-Age Parent Coordinating Council might encourage the expansion of existing curricula or development of a new program.

1. Gather relevant data in assessing need for and potential impact of a sex education curriculum

2. Establish a community coordinating council to develop community awareness of the need for new programs and formulate an implementation plan.
3. Appoint a local Advisory Board.
4. Adopt state or develop local guidelines.
5. Involve parents, pupils and a broad cross section of the community in expressing their needs and planning a program.
6. Identify resources available in the community and from the state including personnel, materials and funding for training and materials.
7. Using the assessment of community needs and the professional literature related to such programs, set realistic goals and expectations about a health and sex education program.
8. Develop a curriculum that
   - Includes the physical and psychological aspects of growth and development throughout the life cycle;
   - Includes human reproduction and reproductive health including the risks of pregnancy;
   - Includes sex roles;
   - Includes sexual behavior and functioning;
   - Includes family planning concepts and methods;
   - Unifies content in health and family life (such as sexuality, childbearing and human development and alternative life styles), in a meaningful way;
   - Brings males and females together in courses concerning the family;
   - Encourages discussion and application of the decision-making process in relation to sexuality and family life;
   - Addresses the concerns of each age group - from childhood through adulthood - with content, methods and materials appropriate to the age and the community.
9. Follow adopted guidelines in implementation of program.

The CHAIRMAN. Thank you, very much.

Mr. Narkunski?

Mr. NARKUNSKI. My name is Abram Narkunski, department head, Atlantic County Department of Social Services, New Jersey.

Atlantic City, N.J., is the central urban area of Atlantic County, which consists of a mix of urban, suburban, and rural development. The city is a typical, albeit small, urban area with a significant proportion of minority and low-income, a high unemployment rate, and a combination of the other characteristic problems associated with urban decay today.

One of those urban problems is the one we are discussing today—that of adolescent pregnancies and, on a wider scope, that of adolescent health.

Twenty-four percent of all births in Atlantic City were by adolescents. Fifty-three percent of all births were illegitimate. These statistics indicate that in Atlantic City we have a crisis. The percentage of illegitimacy is important, because it reflects the prevalence of socioeconomic problems which can affect the well-being of the mother, the fetus, and the infant. Because the highest proportion of illegitimate births occur to adolescents, this too must be considered a high-risk factor. These startling high percentages of adolescent pregnancies and illegitimate births occur in an area where there is more than adequate family planning program which has made a special effort to reach adolescents.

We have postulated that a model delivery system of maternal and infant services would include:

"That every female has the opportunity to choose whether and when she will bear a child, and that her decision is made with a full understanding of the advantages, risks, and responsibilities, of contraception, pregnancy, and parenthood." [Southern New Jersey HSA, Health System Plan for Southern New Jersey, 1978.]

Such options obviously have not been available to the adolescents of this area.

Social workers in the Atlantic County Family Service Unit, who work with the at-risk adolescent pregnant woman or new mother, report that almost all of the adolescent pregnancies were unwanted. Clearly, the option of abortion is not economically accessible to this group. The issue of medicaid funded abortions should be rethought. Abortion has been denied to the low income, and yet there has not been adequate health and social services provided for this target population, with a resulting overloading of present service systems.

It should also be noted that today's adolescents have almost wholly rejected the 19th century solution to adolescent pregnancies of giving up the child to foster care or adoption. Almost all teenage mothers choose to keep their child because of a healthy emotional attachment, because of peer-group pressure, and because of ethnic traditions.

The cause of the high incidence of adolescent pregnancy is difficult to pinpoint. As has been stated, social workers report that almost all of these teenagers involved stated that they did not want to become pregnant, or at least did not consciously desire it. Yet all were aware of the basic biological facts involved, so that complete ignorance cannot be blamed. There seems to be, instead, the incredible naivete—that it could not happen to me.

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Case studies have indicated that emotional deprivation and poor self-image are often a part of the emotional makeup of the teenage mother. Thus, where there is a lack of affection or attention in their own family situation, it can easily be replaced by the attentions of the boyfriend, however selfserving the attentions of the male may be. This gives rise to unwarranted expectations of at least emotional support from the father of the child by the adolescent mother, and these expectations are rarely met.

The causes of adolescent pregnancy must include the economic and social milieu from which most, although certainly not all, come.

But the educational system also must be included. There is generally inadequate sex education courses in most school systems. In private schools, the doctrines of the sponsors prevent it. In public schools, the Boards of Education are far too susceptible to the pressures of parent-groups, which seem to prefer ignorance and fear to adequate sexual information. In other schools, where sex education is included in the curriculum, individual teachers decide to skip over it, because of their own sexual attitudes. In such a situation, it is little wonder that the teenager lacks the knowledge and reasonable attitudes toward his or her own body and sexuality which contribute to good sexual health. Instead, they are forced to rely on the half-truths and superstitions of sex picked up on the street.

In light of the fact that any pregnancy prevention program is not working satisfactorily, the unfortunate plight of the teenage mother must be considered. She has probably dropped out of school when her pregnancy became evident, since this is traditionally expected, and often encouraged by peer and parent pressure. Home tutors are mandated by the educational legislation, but this mandate is indifferently complied with, and she drops behind in her school work.

After the birth of the child, she is often in an independent living situation, either by choice or because of familial pressures. Most schools, perhaps under the incentive of budget pressures, insist on "mainstreaming," for example, that the mother return to the general classroom situation she previously left, when this is totally inappropriate in light of her current needs. She is now in a different social group from her comparatively carefree classmates. She has different educational needs, to gain parenting skills and adapt to her new social role, rather than the traditional academic curriculum, and no provision is made for necessary infant care. Rather than gain the alternative school situation she needs, she is more likely to leave the educational system forever.

The adolescent mother in an independent living situation usually has none of the required skills or understanding to deal with her new fiscal situation. She has no idea of how to rent an apartment, establish a home, or budget a small public assistance check. She is looked on by the potential landlord or creditor as a high risk. She simply has little chance of functioning normally in her new role, on her own, without help.

She also comes from an age group with the worst nutritional habits imaginable, and usually has no understanding of the nutritional needs of a pregnant mother or of an infant. Some cases have been reported in our agency where the adolescent mother does not know that a newborn infant cannot survive on adult foodstuffs. And, she is so lacking

in parenting skills that it is not unusual for her to have been told that it is quite all right to pick up and hold a crying infant, and that some display of affection is desirable.

This problem then is universal and endemic to our whole society. It impacts more at present on low-income and minority groups in the urban areas, but it continues to spread to suburbia and rural areas, and to lower age groups.

The purposes of Senate bill 2910 recognize the problem. The funding levels of $60 million does not appear adequate, when divided between all of the jurisdictions in need of programing in the field of adolescent pregnancy prevention and health.

But more important than the funding level is the opportunity for creative programing in this area. In our locale, some of the social service and health service resources are in place; but like most systems, it is characterized by fragmentation, duplication, competition, and funding constraints, as well as many gaps in the necessary services.

Like most of the social service system, there is a need for a comprehensive approach, with the linkage where appropriate, but more often for an integration of subsystems, to allow a preventative or therapeutic approach to the total person.

In the field of adolescent pregnancy prevention and health a continuum of service is required that assures accessibility from the earliest needs of education and family planning and prevention through the term of pregnancy to adequate followup and aftercare, which guarantees the infant the opportunity of a healthy and normal life.

The only way to provide such a continuum of service is to insure the inclusion of all necessary subsystems of the community in any comprehensive effort funded under S. 2910. In the past, any grant application writer was sure to include letters of endorsement or support from related agencies, and after the grant received approval, these agencies were never heard from again in the funded activity.

It is not enough to include in the grant guidelines or Department regulations that such cooperation is required. It should be included in the legislation that any effort to gain funding of a comprehensive adolescent health program should first secure contractual, although not necessarily financial, agreements which include the participation of the local medical facility providing family planning, the educational system, the public assistance agency, the protective services agency, the community mental health agency, and the community antipoverty agency. Only by such a comprehensive effort can there be an impact on the provision of prevention and care, which is the purpose of this legislation.

Access to such a continuum of care in this field should also be a principal concern of legislative intent. It has been our local experience that the adolescent is reluctant to be seen entering a building marked "Family Planning Clinic," or to sit in a waiting room with her classmates, instead there should be an effort to reach out to the teenager, such as making available preventative services in a shopping mall, which seems to have replaced the soda shop as the place for teenagers to be. Educational and social services could be made available in a neighborhood youth center, so that prevention as well as classes in parenting skills would be accessible in a place where teenagers go for social and recreational purposes.

Creative programing could also extend to other related areas, so that they could have significant impact on the problem under discussion here. For example, the out-of-school youth programs, funded under the Comprehensive Employment and Training Act, could include an infant care facility and classes in parenting skills for the adolescent mother. Or foster care programs could be developed which serve the needs of both the adolescent mother and the infant.

Next, the role of the education system must be considered in any program that is to provide a continuum of adolescent pregnancy prevention and health care. In the past, the educational system has almost completely evaded its responsibility in this field. Yet the school systems have had the greatest opportunity, since they alone have a captive audience of all youth, from the emotionally formative years to the years of high risk of the young teenager.

The process should begin in the lower grades, where children can be approached on a coeducational basis to have respect for their own bodies and their own sexuality. Building upon these healthful attitudes, trained family planning staff can be brought into the school at the appropriate grade level to give a well-rounded sex education which meets the needs of this age group. Such a program may require an active community organization effort to gain parental support, or at least to neutralize opposition, or, it may simply require a legal mandate. In any case, such an educational program must meet the needs of the male adolescent as well as the female, as should all components of a continuum of care in this field.

The educational system must consider the costs of an alternative school setting for adolescent mothers against the costs of losing these people for a lifetime from the educational system, and from the mainstream of life. The combination of an infant-care center and classes in parenting skills within a school setting would allow the adolescent mother to pursue other academic or vocational skills at the same time, and it may prevent a lifetime of subsistance living from public assistance.

Finally, and I may be in opposition with my next recommendation to many of my colleagues, but it is our feeling that it is not rational for a child to bear and rear a child. It is not rational emotionally, psychologically, or sociologically.

We have developed minimum requirements to vote, drink, bear arms, and in other areas, and for good reasons.

Therefore, I recommend that the Senate study the issue of developing minimum age requirements for bearing children. I know that it is in opposition to many thoughts in this field, but this is something that must be looked at. We are in a crisis situation, especially in my area, and dealing with crises we have to deal with very, very different types of recommendations.

In conclusion, I would like to commend the Senate for considering this bill. The importance of its purpose cannot be overemphasized. It can be the incentive for creative programing which can make a significant impact on breaking the cycle of poverty and social immobility which its target population too often represents.

Thank you.

[The prepared statement of Mr. Narkunski follows:]

Atlantic County
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE DEPARTMENT HEAD

1601 ATLANTIC AVENUE, 9TH FLOOR
ATLANTIC CITY, N. J. 08401
(609) 348-3001, EXT. 203
348-3896

ABRAM NARKUNSKI
DEPARTMENT HEAD

DIVISION OF WELFARE
DIVISION OF SENIOR CITIZENS
DIVISION OF YOUTH SERVICES
DIVISION OF CITIZEN SERVICES

TESTIMONY AS GIVEN ON SENATE BILL 2910

A Bill to establish a program for developing networks of community-based services to prevent initial and repeat pregnancies among adolescents, to provide care to pregnant adolescents, and to help adolescents become productive independent contributors to family and community life.

Text to: Committee on Human Resources

Presented by: Abram Narkunski, Department Head
Atlantic County Department of Social Services
New Jersey

Date of Presentation: Wednesday, July 12, 1978

Atlantic County
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF THE DEPARTMENT HEAD

1601 ATLANTIC AVENUE, 8TH FLOOR
ATLANTIC CITY, N. J. 08401
(609) 348-3001, EXT 303
348-3004

ABRAM NARKUNSKI
DEPARTMENT HEAD
DIVISION OF WELFARE
DIVISION OF SENIOR CITIZENS
DIVISION OF YOUTH SERVICES
DIVISION OF CITIZEN SERVICES

Atlantic City, New Jersey, is the central urban area of Atlantic County, which consists of a mix of urban, suburban and rural development. The City is a typical, albeit, small, urban area with a significant proportion of minority and low-income, a high unemployment rate, and a combination of the other characteristic problems associated with urban decay today.

One of those urban problems is the one we are discussing today - that of adolescent pregnancies and, on a wider scope, that of adolescent health. The dimensions of the problem can be seen from the following birth statistics for the area in 1975:

	Total	18 years and younger	% 18 years and younger
		WHITE MOTHERS	
Atlantic County	1843	192	10%
Atlantic City	292	54	19%
		NON - WHITE MOTHERS	
Atlantic County	697	175	25%
Atlantic City	447	121	27%

These figures, it should be pointed out, only include actual births. It does not include the total number of pregnancies, since it is not known how many pregnancies were aborted, either legally or illegally.

Also important in this area are the statistics on legitimacy of birth. The following are figures for 1976.

	Total Births	Legitimate White	Legitimate Non-White	Legitimate % of total
Atlantic County	2544	1609	276	74%
Atlantic City	732	199	141	47%

	Total Births	Illegitimate White	Illegitimate Non-White	Illegitimate % of total
Atlantic County	2544	234	421	26%
Atlantic City	732	83	306	53%

The percentage of illegitimacy is important because it reflects the prevalence of socioeconomic problems which can affect the well-being of the mother, the fetus, and the infant. Because the highest proportion of illegitimate births occurs to adolescents, this too must be considered a high risk factor. These startling high percentages of adolescent pregnancies and illegitimate births occurs in an area where there is a more than adequate family planning program

which has made a special effort to reach adolescents.

We have postulated that a model delivery system of maternal and infant services would include:

> "That every female has the opportunity to choose whether and when she will bear a child, and that her decision is made with a full understanding of the advantages, risks, and responsibilities of contraception, pregnancy, and parenthood".
>
> (Southern New Jersey HSA, Health System Plan for Southern New Jersey, 1978)

Such options obviously have not been available to the adolescents of this area.

Social Workers in the Atlantic County Family Service Unit, who work with the at-risk pregnant woman or new mother, report that almost all of the adolescent pregnancies were unwanted. Clearly, the option of abortion is not economically accessable to this group. The issue of Medicaid funded abortions should be re-thought. Abortion has been denied to the low income, and yet there has not been adequate health and social services provided for this target population, with a resulting over-loading of present service systems.

It should also be noted that today's adolescents have almost wholly rejected the nineteenth century solution to adolescent pregnancies of giving up the child to foster care or adoption. Almost all teenage mothers choose to keep their child because of a healthy emotional attachment, because of peer-group pressure, and because of ethnic traditions.

The cause of the high incidence of adolescent pregnancy is difficult to pinpoint. As has been stated, social workers report that almost all of those teenagers involved stated that they did not want to become pregnant, or at least did not consciously desire it. Yet all were aware of the basic biological facts involved, so that complete ignorance cannot be blamed. There seems to be, instead, the incredible naivete -- that it couldn't happen to them. Case studies have indicated that emotional deprivation and poor self-image are often a part of the emotional make-up of the teenage mother. Thus, where there is a lack of affection or attention in their own family situation, it can easily be replaced by the attentions of the boy-friend, however self-serving the attentions of the male may be. This gives rise to unwarranted expectations of at least emotional support from the father of the child by the adolescent mother, and these expectations are rarely met.

The causes of adolescent pregnancy must include the economic and social milieu from which most, although certainly not all, come.

But the educational system must also be included. There is generally inadequate sex education in most school systems. In private schools, the doctrines of the sponsors prevent it. In public schools, the Boards of Education are far too susceptible to the pressures of parent-groups, which seem to prefer ignorance and fear to adequate sexual information. In other schools, where sex education is included in the curriculum, individual teachers decide to skip over it, because of their own sexual attitudes. In such a situation, it is little wonder that the teenager lacks the knowledge and reasonable attitudes toward his or her own body and sexuality which contribute to good sexual health. Instead, they are forced to rely on the half-truths and superstitutions of sex picked up on the street corner.

In light of the fact that any pregnancy prevention program is not working satisfactorily, the unfortunate plight of the teenage mother must be considered. She has probably dropped out of school when her pregnancy became evident, since this is traditionally expected and often encouraged by peer and parent pressure. Home tutors are mandated by educational legislation, but this mandate is indifferently complied with, and she drops behind in her school work. After the birth of the child, she is often in an independent living situation, either by choice or because of familial pressures. Most schools, perhaps under the incentive of budget pressures, insist on "main-

streaming", i.e. that the mother return to the general classroom situation she previously left, when this is totally inappropriate in light of her current needs. She is now in a different social group from her comparatively care-free classmates. She has different educational needs, to gain parenting skills and adapt to her new social role, rather than the traditional academic curriculum, and no provision is made for necessary infant care. Rather than gain the alternative school situation she needs, she is more likely to leave the educational system forever.

The adolescent mother in an independent living situation usually has none of the required skills or understanding to deal with her new fiscal situation. She has no idea of how to rent an apartment, establish a home or budget a small public assistance check. She is looked on by a potential landlord or creditor as a high risk. She simply has little chance of functioning normally in her new role, on her own, without help.

She also comes from an age group with the worst nutritional habits imaginable, and usually has no understanding of the nutritional needs of a pregnant mother or of an infant. Some cases have been reported where the adolescent mother does not know that a new-born infant cannot survive on adult foodstuffs. And, she is so lacking in parenting skills that it is not unusual for her to have to be told that it is quite all right to pick-up and hold a crying infant, and that some display of affection is desirable.

This problem then is universal and endemic to our whole society. It impacts more at present on low-income and minority groups in the urban areas, but it continues to spread to suburbia and rural areas, and to lower age groups. The purposes of Senate Bill 2910 recognizes the problem. The funding levels of sixty million dollars does not appear adequate, when divided between all of the jurisdictions in need of programming in the field of adolescent pregnancy prevention and health.

But more important than the funding level is the opportunity for creative programming in this area. In our locale, some of the social service and health service resources are in place; but like most systems, it is characterized by fragmentation, duplication, competition, and funding constraints, as well as many gaps in necessary services. Like most of the social service systems, there is a need for a comprehensive approach, with the linkages where appropriate, but more often for an integration of sub-systems, to allow a preventative or theraputic approach to the total person. In the field of adolescent pregnancy prevention and health a continuum of service is required that assures accessibility from the earliest needs of education and family planning and prevention through the term of pregnancy to adequate follow-up and after care, which guarantees the infant the opportunity of a healthy and normal life.

The only way to provide such a continuum of service is to insure

the inclusion of all necessary sub-systems of the community in any comprehensive effort funded under S-2910. In the past, any grant application writer was sure to include letters of endorsement or support from related agencies, and after the grant received approval, these agencies were never heard from again in the funded activity. It is not enough to include in the grant guidelines or Department regulations that such cooperation is required. It should be included in the legislation that any effort to gain funding of a comprehensive adolescent health program should first secure contractual, although not necessarily financial, agreements which include the participation of the local medical facility providing family planning, the educational system, the public assistance agency, the protective services agency, the community mental health agency, and the community anti-poverty agency. Only by such a comprehensive effort can there be an impact on the provision of prevention and care, which is the purpose of this legislation.

Access to such a continuum of care in this field should also be a principal concern of legislative intent. It has been our local experience that the adolescent is reluctant to be seen entering a building marked "Family Planning Clinic", or to sit in a waiting room with her classmates. Instead there should be an effort to reach out to the teenager, such as making available preventative services in a shopping mall, which seems to have replaced the soda shop as the place for teenagers to be. Educational and social services could be made available in a neighborhood youth center, so that prevention as well as

classes in parenting skills would be accessible in a place where teenagers go for social and recreational purposes.

Creative programming could also extend to other related areas, so that they could have significant impact on the problem under discussion here. For example, the Out-of-School Youth Programs, funded under the Comprehensive Employment and Training Act, could include an infant care facility and classes in parenting skills for the adolescent mother. Or foster care programs could be developed which serve the needs of both the adolescent mother and the infant.

Next, the role of the education system must be considered in any program that is to provide a continuum of adolescent pregnancy prevention and health care. In the past, the educational system has almost completely evaded its responsibility in this field. Yet the school systems have had the greatest opportunity, since they alone have a captive audience of all youth, from the emotionally formative years to the years of high risk of the young teenager. The process should begin in the lower grades, where children can be approached on a co-educational basis to have respect for their own bodies and their own sexuality. Building upon these healthful attitudes, trained family planning staff can be brought into the school at the appropriate grade level to give a well-rounded sex education which meets the needs of this age group. Such a program may require an active community organization effort to

gain parental support, or at least to neutralize opposition, or; it may simply require a legal mandate. In any case, such an educational program must meet the needs of the male adolescent as well as the female, as should all components of a continuum of care in this field.

Finally, the educational system must consider the costs of an alternative school setting for adolescent mothers against the costs of losing these people for a lifetime from the educational system and from the mainstream of life. The combination of an infant care center and classes in parenting skills within a school setting would allow the adolescent mother to pursue other academic or vocational skills at the same time, and it may prevent a lifetime of subsistance living from public assistance.

In conclusion, I would like to commend the Senate for considering this Bill. The importance of its purpose cannot be over-emphasized. It can be the incentive for creative programming which can make a significant impact on breaking the cycle of poverty and social immobility which its target population too often represents.

The CHAIRMAN. Thank you very much.

Mr. Narktnski, at the very end there was something I missed, that was not in your prepared statement. Could you go back to that? It was about the minimum age.

Mr. NARKUNSKI. We have a minimum age for driving a car, for a license, and for reasons of being at a certain age you are most likely to be able to drive a car well at a given age, and the same thing we have put minimum ages on people to be able to drink in various States, and the reasons are that 18 or 21, whatever the State has decided, is an age where they can decide for themselves to drink, and many other requirements.

The CHAIRMAN. Is there any minimum age in New Jersey on when you can get married? Is there a minimum age?

Mr. NARKUNSKI. No.

The CHAIRMAN. There is an age where you have to have consent, is there not?

Mr. NARKUNSKI. That is right.

The CHAIRMAN. What is it in New Jersey?

Mr. NARKUNSKI. Sixteen.

The CHAIRMAN. What was your conclusion on minimum age?

Mr. NARKUNSKI. My recommendation is that we study the issue of possibly having minimum age for childbearing. Now, that is an issue that I do not necessarily favor, but I feel it has to be studied because of the crisis we have presently in my area, and there is an extremely high percentage of population right now on pregnancies which are illegitimate, and most go on public assistance in our area.

We in Atlantic County have a caseload on public assistance of approximately 7,000 families, a population of under 200,000, which is twice the average within the State of New Jersey.

The CHAIRMAN. Well, we may come back to this discussion later.

Mr. Lawson?

Mr. LAWSON. Mr. Chairman, I am Quentin R. Lawson, director of human resources for Baltimore City, and I am here to give the official position of Baltimore City government with respect to Senate bill 2910.

You have, I believe, sufficient copies of the testimony, so I will attempt within the next 5 minutes or so to highlight a few salient points.

Whereas I would not like to pass judgment on the recommendation by my colleague from New Jersey, I would certainly recommend that the passage of this bill would not be contingent on the study which is being recommended.

It is the official position of Baltimore City that we speak with strong favor for this bill. Baltimore City, not unlike other metropolitan areas, although showing an overall decline in birth rate, but among the adolescent birth rates the decline is substantially less, and with a particular group we find there is an increase.

As mentioned in the testimony, in 1960, 22 percent of live births in Baltimore were to teenagers. In 1976, the year for which we have the most recent statistics, that has gone from 22 to 30 percent. It is, therefore, imperative that intervention is brought to bear.

I am sure you will agree with me that research has shown that teenage pregnancy results in a number of crippling effects, both to the offspring and to teenage parents. It is crippling in terms of nutrition, crippling in terms of the health needs, and certainly in education, and in the area of employment.

This places a further drain on our already limited existing resources.

With this alarming rate, not unlike other cities, it perhaps suggests that: Is Baltimore working at a program on its own, or is it sitting idly waiting for outside funding?

We have, Mr. Chairman, several components in place in Baltimore City which we think are functional, but it is due to the lack of funds that we cannot, at this point, replicate and expand these programs to become citywide. I will speak to just a couple of them.

We have a new facility, it is a secondary school where we provide some corrective and some primary prevention for teenage parents. But we are unable to replicate and expand this program citywide.

Under title XX we have a project manager here who would be able to answer specific questions. We have also a program supported by title XX funds where we provide the primary prevention and some corrective care in the area of adolescent pregnancy.

We give unequivocal support to the bill. There is one particular strength I would like to speak to, Mr. Chairman, and that is that this bill requires an integration or coordination or linkage among existing programs, both in public and private sector.

We speak to that because that is the vehicle through which the mayor of Baltimore City identifies and attacks problems, not only specific departmental approach, but it is a multidisciplinary approach.

We saw truancy a few years ago as being of high priority in our school system. When our mayor summoned the department heads on a cabinet level to discuss truancy, it was difficult at some point to have the Commission on Aging, or Baltimore City Planning Department, or the Housing Department to identify with the truancy prevention need. But among all human service agencies we were able to develop a multidisciplinary approach to truancy prevention; and as a result of that, we had at the end of the school year 6,000 more youngsters in school per day than we had in recent years in Baltimore City, and that was during the time when attendance nationwide was on the decline.

So we speak strongly in favor of the integrated approach. We know that the Department of Education will have a prime role in this, but it is too often that we place all the social ills into the hands of the Department of Education, public school systems, and their prime responsibility to correct that, as well as teach basic skills, when a youngster with perfect attendance is only spending one-seventh of his calendar year in a school system, and it is unfair to place that major burden of change and behavior metamorphisis on a single institution.

We support the aspect which treats training in sex education. We know that the various institutions, both public and private; currently provide some training, but it is inadequate, it is not relevant.

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Third, the strength is in primary prevention that we certainly would recommend that this be maintained in the bill.

Several additions that we would speak to, and I will at this time quote from the text:

First, a component of pregnancy prevention which we find totally missing from the bill is fostering and development of healthy and positive self-image among adolescents.

We believe that an effective program of pregnancy prevention must look more at the underlying motivations than merely at the surface manifestations.

Having an opportunity to work as director of title VIII, which is dropout prevention, we found that adolescent pregnancy resulted in many cases as a status symbol, youngsters attempting to fill certain voids. It is incumbent among us that not only just in education, in motivation, but the self-concept is important to which it has previously been discussed, that if we attempt to remove this void something else that is more self-fulfilling must take its place.

Senator CHAFEE. Are you suggesting that in some instances that they are intentionally getting pregnant? That is the implication I get. Have you got any rough idea as to what the percentage is?

Mr. LAWSON. We have no data, because a youngster becomes pregnant, and we solicit a cause—it can be one, or it can be multiple causes. We have not set out to identify the number or percentage of youngsters who voluntarily become pregnant, or do this intentionally, but we know that this is a part in some cases of an urban lifestyle, and where if this is a status symbol, that we ought to look at another kind of self-fulfillment which is more meaningful.

Senator CHAFEE. Do the other panelists agree that some of these teenagers—I do not know what the percentage is—are intentionally becoming pregnant?

Ms. BLUM. I think that would—might be phrased a different way, that many teenagers have no other activities to prevent them from entering into parenthood. That if a young woman felt there were jobs that they might have after graduation from high school, there would be a tendency to perform better in school. And that we are in many of our urban areas, also in many rural areas, faced with the fact that young people see a rather bleak future ahead, it is quite acceptable to be a parent at a young age in those same areas.

I think we have a major job ahead of us to turn some of that value system around, and also to provide the other opportunities that are being referred to.

Senator CHAFEE. Thank you.

You say you have increased the school attendance by 6,000. What is the total school population?

Mr. LAWSON. 155,000. That is the enrollment.

Senator CHAFEE. 155,000. And by your efforts you increased the attendance 6,000?

Mr. LAWSON. By 6,000 per day.

Senator CHAFEE. That is pretty significant.

Mr. LAWSON. Yes. We feel that it was because historically we have placed this responsibility on the school system. The youngster at max-

imum being in school from 9 to 3, and if she has perfect attendance, it is only 180 days per year, and if we place that on a time spectrum, it is only one-seventh of a calendar year.

And the school cannot assume that responsibility, but the public housing, and the library, police, and other agencies played a prime role in that. We think a similar scheme, the same model should apply to adolescent pregnancy prevention.

Senator CHAFEE. Thank you

Mr. LAWSON. Second, an absolutely critical area that must be added would focus concern and services on very young teenagers. We must mount an effort that will dramatically reduce pregnancy in the 12-, 13-, 14-, and 15-year-old population.

Third, this bill should contain greater recognition of the need to support and strengthen already existing programs that are well established and successful, given their limited resources.

In an area of shrinking resources, we cannot afford to assume that existing programs have adequate support, or are doing all that they are capable of accomplishing.

The fourth recommendation is it needs to be recognized, even more than the present bill seems to do, that pregnancy prevention is much, much more than birth control services. Birth control services are the easiest part. What is more difficult, and what must come first is the educational and motivational components which will assist you in making responsible and conscious decisions about their own sexuality, whether or not they want to be sexually active, how to deal with sexual pressures, and how to be responsible in their sexual relationships.

Thus, while the health services component is important, it is not the entire package of pregnancy prevention, nor necessarily even the central component.

Fifth, although we emphatically believe that this bill must be, and remain primarily focused on primary prevention, a very important element on prevention must address the needs of the young parents who have already borne one child, but could, with adequate support and assistance, refrain from further childbearing until their education and career preparation is completed.

Sixth and last, we recommend that the bill be amended to contain a very strong component dealing with community education and awareness of teenage pregnancy. For it is lack of adult society's acceptance of adolescent sexuality and willingness to deal with the fact that teenagers are sexually mature, that is much of the reason why adolescents themselves are so reticent to admit their own sexuality, and deal with it responsibly.

The CHAIRMAN. You will have to excuse me, I have got an emergency problem on my hands, and I am going to have to go to the telephone for a few minutes.

Senator CHAFEE. Mr. Lawson, if you would read the next point here, because I think one of the things that this bill needs to focus more on is primary prevention.

Mr. LAWSON. Finally, we feel that the bill needs to much more emphatically and specifically focus its emphasis on primary prevention of teenage pregnancy. All too often programs that are supposed to

be preventive end up focusing on those who already have the problem. Pregnancy prevention which focuses only on young women who are already pregnant will end up as a farce.

What is desperately needed is a major initiative which will dramatically improve our programs of sex education, contraceptive education, community understanding, parental effectiveness, access to birth control services, and the motivations and values of adolescents. The fact of adolescent sexuality must be brought out of the closet. Children and youth must be taught the facts of sex, birth control, and techniques of responsible decisionmaking.

Parents must be taught that more rather than less open discussion with children about sex prevents pregnancy. Teachers, counselors, health professionals, recreation leaders, as well as parents, need instruction in how to effectively discuss sexuality with children and youth. All of this needs to be done before our young women become pregnant.

Teenage pregnancy is a problem we cannot afford to ignore. We cannot afford to have the life opportunities of our young women stunted. We cannot afford to have an ever increasing proportion of our children born into families that are unprepared for them and unable to provide the best of nuturance and support. We can and must do better.

On behalf of the mayor and Baltimore City we applaud this bill before you today, and urge it be made even better and receive the full support of this committee.

Senator CHAFEE. Thank you very much, Mr. Lawson. That is very helpful.

Let me ask a question of Ms. Blum.

How do you think the State government can coordinate these services? From the statements I have read, it is a multidisciplinary approach and has to involve the school in all types of prevention.

As Mr. Lawson mentioned in his statement, education in sexuality, and prevention in birth control devices—how do you think the State can coordinate this?

One of the problems with this bill, as I see it, is that although it deals with teenage pregnancy, as Mr. Lawson indicated, there is not enough on the prevention aspect. There is a great deal of emphasis on caring for the pregnant adolescent before and after she has the child. There is only $60 million for this program which is not going to take us very far.

I just wonder if this bill would not be better off if focused only on prevention and therefore, requiring existing programs to handle some of the other parts that are important. There's no question about it—we are not going to go far with $60 million.

I guess that is kind of a loaded question.

First, how can the State coordinate some of these activities; and, second, what is your view on just restricting it to prevention?

Ms. BLUM. First of all, I believe this, that the State government should play a very major and active role in the coordination of all efforts relating to this particular problem.

As you pointed out, there were multiple agencies at the State and local level which have to be involved in the development of programs.

In order to avoid duplication, in order to use resources appropriately, in the State of New York, and I gather also in the State of Michigan, the State administrations have pooled together interagency efforts.

In New York State, the State department of social services is in the lead. It is our responsibility to work with the other State agencies to understand where the greatest needs are.

I referred during my testimony, Senator Chafee, to a report we just completed in the State of New York. And for the first time we are able to rank our counties in terms of race or pregnancy, live births, abortions, and we also are able to analyze the rate of change that is occurring.

I think that information is important to use.

As you point out, we have limited resources. We have to target those resources.

Now, in terms of what you are asking about, how the money should be spent, I certainly am wholeheartedly with you that prevention has to be a priority effort. However, we have now large numbers of young women who are pregnant and young mothers, and they are straying toward the road toward dependency, both the mothers and the children.

So far as I am concerned, we do have to intervene and we do have to try to help those individuals and, at the same time, focus on preventive aspects.

I believe, sir, that preventive aspects are not expensive to address. If our school system cannot respond, then we have to turn to the media, and whether it is Sesame Street or soap operas, we have got to start getting the kind of information across to the public that we know. There is no question that we have to develop factual information.

This situation reminds me of where we were with drug addiction when we kept developing services and programs to help people who were already addicted, and it was not until we really got the message across to adolescent kids that some drugs were very dangerous that they really began to turn off.

Senator CHAFEE. That is completely different. I agree with you on the drug issue. There are health statistics and plenty of information concerning that.

But you suggest the media, though the media lauds every kind of sexual activity there is. You cannot go to a movie today that James Bond is not in bed with a girl—he spends most of the movie in bed.

Ms. BLUM. What have we done as responsible public agencies to influence that? We have got to do a lot more.

Senator CHAFEE. That is an uphill road to hoe, is it not?

Ms. BLUM. I have always been on uphill roads.

Senator CHAFEE. There is not a movie, except for Walt Disney movies, that does not have this in it. Are we going to change that?

Ms. BLUM. I doubt if we are going to change it differently, but at least we could get some balance, it seems to me. In addition, I think we really have cheated our children. How many children know when the best years of the woman's life may be to bear children? Do we really talk about that to children? No. That is a simple fact. I think children are smart, and I think children understand a great deal if they are told. They are not told what is required to rear children. Little youngsters like to hear about development of infants and tod-

dlers. Why do we not teach them at any early stage what those children require?

We have been deficient in our educational system and in our social service systems in not communicating certain basic facts, I believe, to our young people, and I hope that we will be able to do that.

As I indicated, I think it will be effective, and I do not think it will be expensive.

I just hope we can mobilize together with you to do some of that.

Senator CHAFEE. Ms. Blanchard, any comments?

Ms. BLANCHARD. In the testimony I gave, I mentioned interagency committees at the State departmental level. This approach can be used as a model for solving many problems, including addressing the primary prevention of pregnancy. Our model happens to be involved, at this point, with services to already pregnant women and their children.

However, the interagency committee approach at a State level, I feel, is a workable one, and it can be addressed to many other problems, including primary prevention of adolescent pregnancy. I feel that is where we should put a great deal of attention. In this I agree with the testimony of Ms. Blum that the State should have the major responsibility in providing leadership in developing comprehensive and coordinated services.

Senator CHAFEE. Mr. Chairman, back to you.

The CHAIRMAN. You have opened up so many areas of necessary inquiry, I feel very much frustrated because of the time limitations and our hope to hear so many witnesses today.

Our greatest successes in moving into new areas of program effort with Federal resources across the country have been in activities that have demonstrated their effectiveness.

I can think of community school legislation that we have had success with here in the Senate and in the Congress in recent years, and we expect substantial program effort this year when the Elementary and Secondary Education Act comes up.

We had the advantage there of demonstrated success that came not from Government effort but from a foundation, the Mott Foundation in Michigan.

In another area we have learned, with a lot of professional help, that there were numerous ways to bring education to all handicapped youngsters. Fortunately, we had success in passing this legislation designed to bring resources to communities so that they could have the finances to comply with the Constitution, and that is, give equal opportunity for education to all handicapped children.

I use those as examples, that when we legislated, we knew we were moving with a program effort that would reach a particular goal. I am just wondering if there is any demonstration embracing the comprehensive approach to community needs that will reach young people to prevent the problem of unwanted teenage pregnancy. I know in Michigan there was a model suggested for the new family. That is what it amounts to, is it not?

Ms. BLANCHARD. Yes.

The CHAIRMAN. I know there is a great deal of talk of linking all the services.

We get the feeling that there are few educational systems or programs that have demonstrated effectiveness that are convincing to me, although I got a glimmer of it from the Baltimore program. Am I right, Mr. Lawson?

Mr. LAWSON. Yes.

The CHAIRMAN. You have one secondary school. What this all boils down to is if this bill is enacted, are we professionally ready to receive it, and know our goal can actually reach that objective?

Mr. LAWSON. My answer is we are ready in Baltimore City with our several models that we can see. We mentioned before the number of agencies that provide direct services in Baltimore City to keep our clients independent and self-sufficient. Our mayor has a human resources cabinet through which we convene biweekly and identify problems clients have, and it is through this medium we will be able to develop to the comprehensive and coordinated approach.

We have that model in place.

We have another program that we notice that home visiting was taking place in Baltimore City like many other cities, that you have a health home visitor going in to visit a home and comes out later, the Department of Education had a home visitor going, and then the Commission on Aging would have, and by the end of the day we could have as many as five agencies visiting a particular family and still problems prevail.

We have pulled out of the specialist home visitors and we are using the general approach that they will work all solutions to the problem that is with both parents, the youngsters and with the extended family, physical and human services problems of responsibility of that city service workers, so it is through that model that we are able to implement this program.

The model is in place.

We know we have excellent C and Y or child and maternal programs that are out of Title V that are excellent, and our health clinic. And we do not propose to supplant them, but we want, through this kind of grant, and primary prevention, and further relieve those clinics in C and Y programs into being more effective in counseling and working with parents who already have youngsters.

So I think some cities are in place. I am speaking specifically for Baltimore.

Our project manager of our Title X program, which gives services to adolescent parents, would perhaps speak to that problem and let you know are we able to go to them.

Ms. SCHUYLER. I am Marcella Schuyler, project manager, Special Services for Teenagers, Baltimore, Md.

Baltimore's offorts to assure that the teenagers continue their education program began in 1968 with the establishment of a special school for the pregnant teenagers, and it was very successful in terms of keeping the girl connected with the school in giving her the kind of parent education that she needed.

However, there was a general recognition several years ago that many of the girls were choosing not to go to that school, and that school could only accommodate 800 girls on the average of a year, and there were

3,500 girls who become pregnant in Baltimore City in Baltimore City schools. So we established a parallel program where the girls are mainstreamed into the educational program. In other words, they attend regular classes in regular high schools.

However, we have a support worker there, single parent worker conducts parent education, who gets into birth control groups and tries also to help the teenagers who are at risk of becoming pregnant.

We have been very successful in assuring that the girl returns to school following postpartum absence and seeing that they graduate whenever possible and make sure she stays connected with her health program.

So I think that Baltimore City has been able to demonstate two effective programs. However, we are not able to reach all the schools in the city because we do not have this program in place in every high school.

But maybe with this legislation, we can do something about it.

The CHAIRMAN. Very helpful.

Does anybody else have any words of wisdom that can generate hope that we know how we can be effective with the Federal program?

Ms. BLUM. I think we have in a number of our counties in New York State programs which need to be replicated where they do not exist. Syracuse, Rochester, Buffalo, New York City. They are really model programs that have been developed, shown to be effective. We simply need Federal assistance so we can extend those programs to other youngsters who are not receiving such service.

Mr. NARKUNSKI. One of our problems is funding. We have used funding, Title XX source, with a ceiling, with other priorities, and it is just becoming lesser a priority, with life and death situations in other Title XX areas.

One of our downfalls has been that there has not been a good tie into the educational system.

I do not want to say there has been much said about the private agencies providing other services, such as family planning in other area services, and they are very instrumental, I believe, in the development of any program. That is why I mentioned this recommendation that contractural agreements be made with all agencies who will be part of this network.

The CHAIRMAN. If you could supplement your very, very helpful statement today with a description of some models you would recommend for application to communities that have not instituted programs at the level of your expertise, it would be very useful to us.

Thank you very much.

Ms. BLUM. Thank you.

Mr. NARKUNSKI. Thank you.

[The prepared statement of Mr. Schaefer supplied for the record follows:]

City of Baltimore

Office of the Mayor

William Donald Schaefer, Mayor

Testimony

S.2910

The Adolescent Health, Services, and Pregnancy

Prevention and Care Act of 1978

Senate Committee on Human Resources, July 12, 1978

It is with pleasure that we appear before you to address, on behalf of the Mayor of Baltimore City, William Donald Schaefer, the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978.

Baltimore is the seventh largest city in the United States, an older industrial city that is experiencing the kind of rebirth and rejuvination to which many other cities look with envy. While Baltimore is no more free of problems and challenges then any other older eastern industrial city, it is blessed with creative leadership, sound fiscal policies, a mood of optimism, and an exceptionally beneficial government structure in which the City lies within no county or other government unit except the state, making for an unusually well-integrated human services network. With virtually all public human services responsible and responsive to the Mayor, including employment, welfare, housing, education, health, social service, leisure and culture, fire, police, and corrections, a degree of integration of services is poesible in Baltimore unthinkable in most major cities.

I say this because Baltimore has recently, apart from any possible impact of the legislation currently receiving your consideration in these hearings here today, turned its attention to the issue of teenage pregnancy. Our approach, as we have sought to develop a strategy to reverse the trend of statistics on adolescent childbearing, has been to develop linkages between all of the relevent agencies which must be mobilized to implement a comprehensive plan integrating education, staff training, community awareness, motivational change, as well as improvement in access to birth control services.

Briefly, our intention and direction has been to create out of many presently separate and disparate elements a single integrated and multi-disciplinary plan of action to address simultaneiously the many components of adolescent pregnancy. The initistive and continued guidance for this effort has come from the Office of the Mayor. It is anticipated that adolescent pregnancy prevention, along with parenting education, will be the primary focus of the emerging City Commission on the Family, presently also being formulated by the Mayor's Office.

It is within the context of a major city's commitment to reverse the trend of teenage pregnancy that, on behalf of Mayor Schaefer, I appear before you to comment upon the proposed Senate Bill 2910. The comments here presented will focus first on the strengths of the Bill, then on the specific dimensions of the problem of teenage pregnancy as we witness them in Baltimore, and finally on the additional elements we would like to see included in the Bill to make it even better.

Our most fundamental comment on the Bill is "Thank Heavens!" Thank Heavens, thanks to Senators Kennedy, Williams, Javits, and Hathaway, and all of the multitude of others who have brought the issue this far. For no longer can we hide from this issue; no longer can we hope that childbearing by adolescents who are hardly more than children themselves will go away if we continue to ignore it. No longer can we afford to ignore the fact that an ever growing proportion of our children arrive uninvited, unplanned, to unprepared adolescent parents.

We strongly applaud the basic direction of this Bill, recognizing as it does the complex and multi-faceted nature of the problem. Prevention of teenage pregnancy requires the effective linkage of many different, yet closely inter-related, services. Better sex education alone will not solve the problem. Better and more accessible adolescent health and birth control clinics alone will not solve the problem. Increased community awareness and concern alone will not solve the problem. These services must be linked together in a truly integrated network in which each actively reinforces the other.

Pregnancy prevention cannot be sufficiently achieved by more birth control clinics alone. With solid research evidence showing that the vast majority of teenagers do not use any means of birth control until they have been sexually active for some time, there obviously must be a great deal of effort focused on education and motivation.

We are convinced that it is in the area of education and attitude change that the greatest attention must be focused. Too long have we been reticient to do a really adequate job of sex education. Too long have we allowed fear of those who oppose objective sex education to dictate what we will teach or not teach. Too long have we hoped that what our children and youth do not know about sex will not hurt them. But research proves that what youth do not know about sex does hurt them, and hurt their unintended children.

We applaud the fact that the Bill calls for innovation and testing of new methods of education, motivation, and service delivery. Especially important, in our view, is the development and testing of new techniques of integration and networking of services, outreach, and staff training.

The situation in Baltimore is probably not unlike that of other major cities. We find that while the general birth rate has declined significantly, from 116 births per 1,000 childbearing age women in 1960 to 58 births per 1,000 women in 1976 (a 50% reduction in 16 years), the birth rates for teenagers have not shown parallel declines. The general birthrate for women 15 to 19 declined by 38 percent from 120 births per 1,000 15 - 19 years old women in 1960 to 74 per 1,000 in 1976. The rate for black women 15 to 19 however, declined by 53 percent, from 181 births per 1,000 black 15 - 19 year olds in 1960 to 86 per 1,000 in 1976. The rate for white 15 to 19 year olds showed a much smaller decline of only 37 percent, from 82 per 1,000 in 1960 to 52 per 1,000 in 1976. The most distrubing data, however, relates to birth rates for young women 10 to 14 years of age. From 1960 to 1976 the rate of births to 10 to 14 year olds shows no decline at all, resulting from the balancing of a 39 percent decrease in births among black 10 - 14 years olds and a 140 percent increase in births to 10 - 14 year old whites.

Clearly, the most disturbing and difficult problem is among younger adolsecents age 14 and under, and with young white girls specifically, among whom the birthrate is increasing dramatically.

The major dimension of the problem, however, is that while all birthrates (except 10-14 whites) are declining, teenage birthrates are declining less rapidly then birthrates among older women, resulting in a greater proportion of our children being unintentionally born to teenagers who are unprepared for parenthood, unprepared for life, unprepared to support and nuture children while they are still children themselves. In 1960 in Baltimore, 22 percent of all live births were to women 19 and under. By 1976, 30 percent of all live birtha were to teenage mothers.

The final critical dimension of the situation as we see it in Baltimore concerns the numbers of women having repeat pregnancies while still in their teenage years. In 1976, over 1,100 teenagers had a second, third, or fourth child; 336 age 17 or under had a second, third, or fourth child.

Since a number of studies have conclusively shown that a second birth to a teenager makes continued education and/or job training virtually impossible, one of our greatest priorities is to reach the young woman who has already borne one child and do everthing possible to encourage and assist her to complete her education and become economically self sufficient before she has another child.

In light of our concern, commitment, and the current situation in Baltimore, there are a number of suggestions we would like to present that, in our view, would significantly strengthen the Bill.

First, a component of pregnancy prevention which we find totally missing from the Bill is the fostering and development of healthy and positive self-image among adolescents. We strongly believe that an effective program of pregnancy prevention must look more at the underlying motivations than merely at the surface manifestations. Our review of the best reaearch litersture on adolescent pregnancy and adolescent development indicates to us that much of the motivation for early childbearing, albeit often unconscious, is the desire for status and role clarification that (it is thought) parenthood confers. It must seem to many young people in our society, especially at the lower economic end of society, that their most significant status comes from the simple biological function of producing children. For if a young woman has no visiion of

herself and her futura that is loftier than her parents knew, if she has no expectations of life that a baby will seriously interrupt, then she has little motivation to resist sexual activity or to prevent impregnation. Likewise if young men have no visions of their future that provide them with an inner sense of worth and value, if they have no expectations of life that the responsibilities of child support will inhibit, if they have no respect for the worth and value of their female peers other than as sexual objects, then "scoring" with the young women and impregnating them become their chief source of a feeling of importance and status. But how tragic that we should be raising young adults whose self-images are so vacuous that adolescent childbearing is their chief source of status and worth; how tragic to be raising a generation whose sense of the future is so empty that a severe reduction of educational and career opportunities as a result of teenage childbearing seems to be no loss; how tragic that we are raising a generation of young adults who do not have a vision of their future that is exciting and enticing enough to make pregnancy prevention a high priority for them.

If we would truly seek to have our adolescents avoid early and untimely pregnancies, then we must deal seriously with their need to be encouraged to develop and pursue concepts of self-worth and future opportunities. A sense of self-worth and optimism about their futures will provide them with the motivations to avoid the pregnancies which would diminish their future opportunities and stunt their possibilities. If we are serious about teenage pregnancy prevention we cannot afford to neglect the matter of the adolescents' self-images.

Second, an absolutely critical area that must be added would focus concern and services on the very young teenagers. We must mount an effort that will dramatically reduce pregnancy in the 12, 13, 14 and 15 year old population. Few things in life are so tragic or absurd as a 12 or 13 year old child having a child. Yet it is this age group that we are failing to reach with any of the current preventive efforts. It is the very young teenagers whose birthrates are staying stable or even increasing. It is the very young teenager who is generally exempt from what sex and contraceptive education programs as do exist. It is the very young teenager who has so little concept of the future and his or her place in the future that there is little motivation to avoid pregnancy. It is the very young teenager who has least access to such birth control services as do exist. It is the very young teenager who most lacks both the knowledge and motivation to utilize birth control or to refrain from sexual activity. It is the very young teenager for whom we do the least by way of pregnancy prevention, but for whom pregnancy is the greatest tragedy.

Third, the Bill should contain much greater recognition of the need to support and strengthen already existing programs that are well established and successful given their limited resources. In an era of shrinking resources we cannot afford to assume that existing programs have adequate support or are doing all that they are capable of accomplishing. We find, for example, that valuable and proven services are often withering for lack of adequate financial support, especially as constant level funding is rapidly eroded by inflation.

Fourth, it needs to be recognized even more than the present Bill seems to do, that pregnancy prevention is much, much more than birth control services. Birth control services are the easy part; what is more difficult and must come first is the educational and motivational components which will assist youth in making responsible and conscious decisions about their own sexuality, whether or not they want to be sexually active, how to deal with sexual pressures, and how to be responsible in their sexual relationships. Thus, while the health services component is important, it is not the entire package of pregnancy prevention, nor necessarily even the central component.

To the extent that health services are important, however, the focus should be clearly and emphatically on establishment of a continuity of care rather than clinics that deliver primarily crisis care. In the pregnancy prevention system that Baltimore is attempting to develop, for example, we are looking to the hospitals, primary care centers, and health maintenance organizations to develop a city-wide network of comprehensive adolescent health care programs that are integrated into the health and sex education programs of the schools and other community institutions for purposes of outreach. We aim to involve adolescents in regular and continuous health care in which birth control is only one element delivered on an as needed basis in the context of total health care.

Fifth, although we emphatically believe that this Bill must be and remain primarily focused on primary prevention, a very important element of prevention must address the needs of the young parents who have already borne one child but could, with adequate support and assistance, refrain from further childbearing until their education and career preparation is completed. If we dare not be so shortsighted as to deal only with the already pregnant and already parents, neither dare we ignore the critical position of the adolescent who is already a parent. Adolescent parents are often in desparate need of counseling, educational or vocational training assistance, housing, and other supportive services. With greater assistance, adolescents who are already parents can be helped to keep an impediment to their development from becoming the one-way street to poverty and dependence it has traditionally been.

Sixth, we recommend that the Bill be amended to contain a very strong component dealing with community education and awareness of teenage pregnancy. For it is lack of adult society's acceptance of adolescent sexuality and willingness to deal with the fact that teenagers are sexually mature that is much of the reason why adolescents themselves are so reticent to admit their own sexuality and deal with it responsibly.

Finally, we feel that the Bill needs to much more emphatically and specifically focus its emphasis on <u>primary</u> prevention of teenage pregnancy. All too often programs that are supposed to be preventive end up focusing on those who already have the problem. Pregnancy prevention which focuses only on young women who are already pregnant will end up as a farce. What is desperately needed is a major initiative which will dramatically improve our programs of sex education, contraceptive education,

community understanding, parental effectiveness, access to birth control services, and the motivations and values of adolescents. The fact of adolescent sexuality must be brought out of the closet. Children and youth must be taught the facts of sex, birth control, and techniques of responsible decision-making. Parents must be taught that more rather than less open discussion with children about sex prevents pregnancy. Teachers, counselors, health professionals, recreation leaders, as well as parents, need instruction in how to effectively discuss sexuality with children and youth. All of this needs to be done before our young women become pregnant.

Teenage pregnancy is a problem we cannot afford to ignore. We cannot afford to have the life opportunities of our young women stunted. We cannot afford to have an ever increasing proportion of our children born into families that are unprepared for them and unable to provide the best of nuturance and support. We can and must do better.

On behalf of the Mayor and Baltimore City we applaud this Bill before you today, and urge it be made even better and receive the full support of this Committee.

As Kenneth Keniston and the Carniege Council on Children have written:

> Our society needs the best adults we can make, adults who are caring, resourceful, moral, whole, and physically healthy. When we fail to support the development of the next generation and of the families that nurture them we deprive ourselves and the nation of a part of our children's potential. Children who lose a sense of a decent future are likely to become dispirited, angry, withdrawn, and outraged. (All Our Children, pp. 215-16)

The CHAIRMAN. We will hear from our next three panelists Mrs. Marjory Mecklenburg, Ms. Meg Rini, and Ms. Jessma Blockwick.

STATEMENTS OF MRS. MARJORY MECKLENBURG, PRESIDENT, AMERICAN CITIZENS CONCERNED FOR LIFE, INC., MINNEAPOLIS, MINN., ACCOMPANIED BY MS. MEG RINI, DIRECTOR OF MARIE HENDRY AND MAGDALENA HOUSES OFFERING RESIDENTIAL CARE FOR PREGNANT WOMEN, CHERRY HILL, N.J.; AND MS. JESSMA BLOCKWICK, DIRECTOR, DEPARTMENT OF POPULATION, UNITED METHODIST BOARD OF CHURCH AND SOCIETY, WASHINGTON, D.C., A PANEL

Mrs. MECKLENBURG. Thank you.

Senator Williams, I am pleased to be here today to discuss the adolescent pregnancy bill.

But first, I wish to express my appreciation for your leadership on behalf of this bill, the pregnancy disability bill, the black market baby bill; all of which are legislative priorities of American Citizens Concerned for Life.

When we were founded during the 93d Congress, our executive director appeared in testimony before the Senate. He pledged that we would work in partnership with Members of Congress, the administration, and the private sector to insure that children, both born and unborn, would be protected and cared about and that pregnant women and families would have an opportunity to bear and nurture their children.

We are very gratified for the interest of Congress and the administration in this bill, which we consider a very significant and helpful piece of legislation.

Adolescent pregnancy is of deep concern to many people in this country. It has captured the attention of a broad spectrum of society.

As a member of the voluntary segment I am excited to see the growing interest in responding to the needs of the pregnant adolescent, her family and her child.

I have had the opportunity to see a number of voluntary services that assist adolescents and I marvel at the commitment and the time that is being spent, often without the benefit of Government or foundation funding in order to respond to the tremendous need that exist. Later we will have an opportunity to hear from Meg Rini, who is directing such a program.

Unfortunately, many pregnant adolescents live in a community where they do not have adequate services available. This is particularly true in rural areas and some of the large metropolitan areas where the leadership has not yet emerged to provide such assistance.

I am not going to discuss in detail either the need for or the merits of a comprehensive service approach today because I have submitted a very detailed statement to the committee covering these topics.

I would prefer to address some specific points which have been raised by previous panel members and make some definite suggestions

for improving the bill. However, I would be pleased to answer questions about all aspects of this bill.

At the outset I want to clarify that I believe this bill has many strengths. Implicit in it is the recognition that human beings are important and worthwhile. It emphasizes helping pregnant women and their children achieve their potential by intervening in the destructive pattern which may exist when adequate services are lacking. The positive pro-life focus of S. 2910 is the central reason our organization supports its passage.

We also see the disciplinary thrust of the bill as another strength. My husband is an obstetrician-gynecologist. I am not unaware or unappreciative of the physician's approach to a woman facing the problem of an unintended pregnancy. This bill recognizes the medical component as an essential element in the response to pregnant adolescents, but it also identifies additional elements that are necessary to achieve optimum care for these young women and their children. The medical profession in isolation from other services cannot provide the supportive environment and special education that is needed. We are encouraged that the bill addresses the various elements that are necessary to address this crisis in a young woman's life.

We also appreciate that this bill encourages community activity and eventual assumption of responsibility for these necessary services. It is clear that there is substantial negative reaction to a permanent caretaker role for the Federal Government. The concept of shared funding and declining percentage of Federal funding, and the emphasis on linking existing community resources puts the Federal Government in the role of a catalyst acting as a partner with local communities. I see this role as desirable and acceptable. I believe the concept of cooperation would be further extended by including an advisory committee which would make suggestions to HEW on guidelines to be implemented and on program evaluation. If individuals who are receiving and providing services, professional groups, and organizational representatives serve on the advisory committee, the channels of communication could be kept open and various segments would have an ongoing opportunity to work together to make this program effective.

We favor a higher percentage of money for evaluation and additional money for programs. This is particularly important if primary prevention is to be a strong component of the bill. Because we see that this legislation addresses a very large problem we are concerned that the funding suggested may not be adequate.

We support S. 2910 as is, but believe that more money could be utilized effectively.

I would like to comment briefly now on some of the testimony of previous panel members.

I especially appreciate your statement, Senator Williams, that the Federal Government has been able to fulfill its obligations and be most helpful when a program has demonstrated its effectiveness and the Federal Government has been able to assist in increasing its availability.

We believe this insight could be applied when making a decision about how large a percentage of the funds in this bill should be used for primary prevention.

It can be demonstrated that comprehensive supportive service programs are effective. Model programs exist in which there is at least short-term evaluation.

The CHAIRMAN. Could you excuse me for a minute, I have an important phone call. I would like to pick it up right there.

Mrs. MECKLENBURG. All right. Thank you.

[Short recess].

The CHAIRMAN. Please continue.

Mrs. MECKLENBURG. I was addressing a question of primary prevention moneys versus supportive moneys in this bill. I would agree with your analysis, Senator Williams, that governmental assistance can be effective when model programs already exist.

It has been established that the availability of comprehensive supportive services make a significant difference in the future of pregnant adolescents and their children. I refer here to the testimony I have submitted and that of other witnesses. Everything is not in place but a specific direction has been charted. I feel that in funding the wider availability of supportive services the Federal Government would be on firm ground.

Primary prevention is a more difficult area to assess. A great deal of contraceptive knowledge and literature exists, but overall in the area of primary prevention a consensus on how to proceed is not apparent. One of the reasons we have so much dissension in this country over questions about sex education is that we really do not know the effects of various types of programs. We are only sure that some approaches do not work very well for some people. Contraceptive services are effective tools in pregnancy for some adolescents—but not an adequate response or approach for many adolescents.

We would like to see the prevention component in this bill utilized in the search for and evaluation of innovative model programs rather than for implementation of existing approaches. Contraceptive services are already funded under other legislation.

I have a strong interest in family life education because I was a home economics teacher a number of years ago. An understanding of bodily functions, child development, human relations, and parenting skills can greatly improve the ability of a young person to make responsible choices. However, I do not think that we are at a stage where we can say what kind of program has predictably good results. Therefore, we feel the majority of the money made available through this bill should go to supportive service programs with a smaller percentage aimed at demonstration primary prevention programs.

I feel compelled to comment briefly on the earlier testimony that we ought to limit childbearing because I was quite shocked by that statement. I have heard the suggestion from professional workers in the field that some minimum requirements for keeping and raising a child should be considered. Even this is a very controversial suggestion. But to recommend that the Government should intervene and regulate who should be allowed to bear children is unthinkable. I believe the best approach is to make available services to help young women give birth safely and improve their parenting skills.

Abortion funding was raised as an issue which the Congress should rethink and several witnesses suggested that abortion be included in

this bill. We believe abortion services should not be included in this bill. The consensus of the people of the country, according to all of the polls I have seen, is that they are not willing to use their tax money for funding abortions. But, interestingly enough, the latest polls show also that people are willing to utilize their tax money to help needy pregnant women with services. This is a bill on which people who differ on the questions of abortion legality or abortion funding should be able to agree. We should be able to stand together and to work together to help women who choose to continue pregnancy receive the services they need. We should also be able to make progress together toward reducing the incidence of unintended pregnancy in the adolescent population.

If abortion is interjected into this bill, I believe it will reduce or eliminate its chances of passage and this bill will become another focus for a debate over abortion funding.

Senator Chafee addressed the problem of the sexually permissive climate we live in. My final comment concerns his statement. It is clear that young women and men, as well as unborn children, are victims of this new freedom. We have not given our young people the tools they need to make responsible decisions involving their sexuality. I think that is extremely important that we make an effort to do so.

Most of us would agree that just contracepting adolescents is not an adequate response to their needs in this area. Earlier today I heard excellent testimony underscoring the importance of considering the total person and their relationship with their family and other persons in formulating programs for adolescents.

I strongly agree that this is crucial in dealing with sexuality, pregnancy prevention, and pregnant adolescents. I do see S. 2910 as a panacea but as a critical step in creatively and effectively responding to adolescent pregnancy problems.

We urge your support for this bill. Thank you.

The CHAIRMAN. Thank you ever so much.

You have a longer statement that we will include in the record.

Mrs. MECKLENBURG. Yes.

I also appeared before the Select Committee on Population on this topic, and I have shared that testimony with the committee. In the last Congress I testified on this issue before Senator Kennedy and Senator Bayh and have also submitted that to you.

The CHAIRMAN. Thank you.

Mrs. MECKLENBURG. Thank you, Senator Williams.

[The prepared statement of Mrs. Mecklenburg follows:]

STATEMENT BY

MARJORY MECKLENBURG

FOR

THE SENATE HUMAN RESOURCES COMMITTEE

ON

"THE ADOLESCENT HEALTH, SERVICES AND PREGNANCY PREVENTION AND CARE ACT OF 1978, S.2910"

JULY 12, 1978

Senator Williams, members of the Human Resources Committee, I welcome the opportunity to appear before you today as president of American Citizens Concerned for Life, a national pro-life organization, to speak in support of the "Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978," S.2910.

ACCL has had a long-standing interest in pregnant women, children and the family. Our overall purpose is to motivate each individual, and society as a whole, to make decisions about the use of available resources based on the premise that each human being has great value and that individuals should have the opportunity to realize their full potential.

ACCL is an advocate for both public and private sector programs to improve and safeguard the lives of pregnant women and children -- both before and after birth. During the 94th Congress I testified in behalf of bills authored by Sen. Kennedy and Sen. Bayh which focused on these needs. With your permission, Sen. Williams, I would like to enter those statements in the record of this hearing along with testimony I presented last March before the House Select Committee on Population.

The number of adolescent pregnancies and the problems surrounding this phenomenon have been of growing concern to the Administration, members of Congress and the public. About one million adolescent girls -- one in ten aged 15 to 19 -- become pregnant each year, the majority out of wedlock. Of these one million girls, 400,000 are 17 or under; 30,000 are 14 or under. While some teenagers are married and wish to become pregnant, a substantial

number of teenage pregnancies are unwanted; well over 300,000 teenage abortions were reported in 1976 to the Center for Oisease Control.[1] Dr. Wendy Baldwin, social demographer from the National Institute of Child Health and Human Oevelopment, in her statement before the Senate Human Resources Committee on June 14, reported that for adolescents "birth rates are still high, increasing numbers of births are out-of-wedlock, control of fertility is still poor, and the exposure to risk is increasing."[2]

S.2910 will make available services which adolescents need to avoid becoming pregnant or to continue a pregnancy already begun, and we support the bill on this basis. We believe that adolescents who choose to continue a pregnancy despite the hardships they encounter are deserving of our compassion and our practical assistance. "Freedom to Choose" implies that it is equally possible for a woman to choose to give birth as well as to abort. Today frightened, confused and dependent adolescents often have little freedom to continue a pregnancy unless the kind of services this bill details are readily available.

Most pregnant adolescents and their babies have a bleak future. The adolescent faces a multitude of phychological, psycho-social and health complications as a result of early pregnancy. These young women have to cope with the developmental tasks of adolescence, while shouldering the demands of early childbearing and rearing. Some of the girls who are pregnant at this early age have multiple problems, such as unstable family backgrounds, and low self-expectation and esteem. Unless the pregnant adolescent receives adequate counseling and services she may become phychologically impoverished (depression and suicidal attempts), a school dropout, have repeat pregnancies, or become a vicitim of unemployment and long-term reliance on welfare.[3,4]

Many girls who are pregnant out of wedlock do not report for medical care until very late in pregnancy. Therefore, a vast majority of them receive inadequate health care and are undernourished. When this is the case, they face significant risks both for themselves and for their babies.

They are more susceptible to death from toxemia of pregnancy (maternal mortality is 60% higher among teenagers who do not receive adequate prenatal care).[3] Their children are more frequently premature, and often have such complications as increased susceptibility to infections, hypoxic brain damage, nutrition related congenital defects, and developmental disabilities, including mental retardation and learning disabilities. Infant mortality can be as much as 2.4 times higher for babies born to teenagers than to 20-24 year old mothers.[4]

As we investigated what is being done to assist the adolescents who are facing this crisis, we concluded that a comprehensive approach which provides both medical care and psycho-social support can dramatically improve the outcome for both mother and baby. With adequate medical care, attention to nutrition, and help in psycho-social areas most of these women will deliver safely.

However, the needs of pregnant adolescents are so diverse and complex that a program directed at only improving medical care has proven to be inadequate. Adolescents in general are notably poor users of health care services, and pregnant adolescents in particular are sporadic users of prenatal care. This may be because of ignorance, fear, or negligence. They may have

anxiety about possible ostracism or judgmental attitudes by adults. They often see existing services as not meeting their needs and thus not "approachable."

But when their psycho-social needs are met and adequate counseling and support are available in combination with medical care there is evidence that adolescents will report early for prenatal care and will keep appointments with the physician.

It is important to provide excellent care for this age group in a place that is comfortable for them -- a place in which they may have had a previous positive experience is ideal. For example, when comprehensive care centers are located in schools, the girls tend to come in early for pregnancy care. The teenage grapevine and referrals often inform the pregnant girl where helpful supportive services can be found.

The basic components of successful comprehensive adolescent pregnancy programs are:

1. Early detection of pregnancy and comprehensive prenatal care.
2. Social services to help adolescents cope with emotional, financial and community problems.
3. Comprehensive health care for the infant.
4. Long-term follow-up services for a minimum of two years.
5. Education -- to encourage completion of schooling and provide parenting and family life instruction.
6. Adequate day care.
7. Procedures for involving fathers.

8. Involvement of community supporters.
9. Staff training and education.
10. Transportation resources.
11. Prevention of pregnancy.
12. Evaluation methods to determine success or failure.

Providing comprehensive services to pregnant adolescents appears to be realistic and cost effective over both the long and short term. Girls who utilize comprehensive programs are less likely to have repeat out-of-wedlock pregnancies and they are less likely to rely on welfare assistance programs for long periods of time. Adolescent mothers who receive adequate medical care have a lower rate of obstetrical complications which would affect their health and that of their children.[5,6]

There is evidence that comprehensive care programs are also an effective means of reducing the number of first pregnancies in the community of adolescents who have contact with such programs. Failing to allocate the resources necessary to provide comprehensive care for pregnant adolescents will result in the need to expend even more to deal with the resulting consequences.

Few pregnant adolescents have access to comprehensive programs. Model programs are available in very few areas. Even where services exist in a community the different elements may be scattered and coordination may be lacking. Young women may not know how to find the assistance they need. Continuity is an important factor in treating adolescents and through this legislation various agencies will be encouraged to seek more coordination and cooperation so that the pregnant adolescent is considered as a whole

person. We believe that there is a strong case for both more services and better linkage of already existing services.

Because the need for supportive services for pregnant adolescents is urgent and the comprehensive approach has been shown to be effective we would favor increasing the funding authorization in this bill. We would also recommend that the percentage allocated to evaluation be increased. As representatives of the voluntary sector we believe it is crucial that a citizen advisory committee to HEW be formed to recommend guidelines for these programs and to assist in evaluating them. This committee should be broadly representative of the groups that are interested and involved in such programs, and of the people being served by the programs. One of the strengths of this bill is its attempt to involve communities, to allow them flexibility, and to encourage their eventual assumption of responsibility for funding and control. This process will be hastened if a mechanism for ongoing interaction is established between providers and advocates in the field, those being served, and professionals in HEW who are administering the programs.

In addition to authorizing supportive health services and care, S.2910 also provides for pregnancy prevention programs, although it is not clear what percentage of the funds is intended for that purpose. Surely, there is general agreement that prevention is an important aspect of dealing with the problem of adolescent pregnancy. Of the one million adolescents who become pregnant each year abortion statistics would indicate that many did not wish to become pregnant but were not sufficiently educated or motivated to prevent it. Unless we discover effective ways to encourage responsible sexual behavior in the

adolescent population, this situation is unlikely to change in the near future. Dr. Wendy Baldwin reports that "Between 1976 and 1980 we can expect the number of 14-17 year olds to decrease by 6.7%. If the proportion of those who are sexually active continues to increase, however, the net effect may well be an increase in the absolute number of adolescents at risk of pregnancy."[2]

Surely such a situation is unacceptable. The high degree of sexual freedom that exists in our society today calls for increased personal responsibility and self-control. Yet we have not been able to give young people the kind of help they need to live in such a climate and cope with their own sexuality.

Traditional family planning programs have not provided the kind of approach many young people are seeking. Even where such services are readily available they may not be utilized by sexually active teens.[7] In addition, the possible adverse effects of long term usage of IUD's and oral contraceptives are a matter of growing concern, as are the other medical problems faced by sexually active teens.[8]

We must develop educational approaches to pregnancy prevention which will focus on sexuality in the broader context of life experiences. It is important to place family planning and human sexuality education in such a context and to structure programs so that they are not isolated technological services devoid of morality, family involvement and other elements that are crucial in an adolescent's life.

I personally don't believe that anything is gained by withholding family planning services from adolescents after they are sexually active. Such a

policy only increases the possibility of pregnancy, pressure for abortions and other problems sexually active adolescents may have. However, contracepting adolescents is not the only or optimum solution to preventing adolescent pregnancy. Many of us would like to see programs which would encourage young people to choose to value themselves and their sexuality and to postpone sexual involvement. Yet today there appears to be little emphasis on this approach and little encouragement for adolescents who choose this option. Current role models tend to glamorize the sexually active teen.

It would be our position that the primary prevention funds made availalbe through passage of this bill should be directed at research and development of model programs to foster new and comprehensive approaches to preventing adolescent pregnancy. Contraception programs are substantially funded through other federal legislation.

In summary, we in ACCL believe there is a strong case for passage of this bill. The voluntary sector is responding to pregnant adolescents but has not been able to adequately meet the complex needs of these troubled individuals without governmental assistance.

Your recognition of the problems they face and your stimulation of appropriate services will substantially improve the future for many young mothers and their babies.

8

REFERENCES

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2. Baldwin, Wendy, Testimony Before the Senate Human Resources Committee, June 14, 1978.

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The CHAIRMAN. Next, please.

Ms. RINI. My name is Meg Rini. I live in Cherry Hill, N.J. Please accept my deep gratitude for the opportunity to appear before you today on this most vital social and family issue. That you on the national level have expressed interest in teenage pregnancies is evidence of the magnitude of the problem.

My long personal interest and involvement in these matters began with service as a volunteer for a crisis pregnancy center. In time, I became the director of that center, and later established two additional centers as the need for such service grew and became obvious. All three of these centers are located in the southern part of New Jersey, with one of them servicing inner-city minority women by providing bilingual volunteers, counseling, and informational materials to accommodate the needs of the large Spanish-speaking population. As a result of this experience, I quickly recognized the need for residential care for pregnant girls.

In order not to duplicate services already available, I researched the matter of such residential facilities. The investigation clearly established that in the entire southern part of the State of New Jersey, from Trenton and below, there was not even one such facility. Responding to a tremendous need, I set out to make such a haven a reality for those girls and women who had no place to go.

The concerns and problems I share with you today, therefore, grow out of my experience with the two prenatal residential centers which eventually came into being, and are still today the only such centers available in all of south Jersey. They are facilities which are entirely staffed, operated, and funded by the private volunteer sector, since I found there were no community, State, or Federal moneys available to deal with this particular need of women with problem pregnancies. Consequently, the care and assistance we can provide is limited to the generosity of interested people, the ability of the pregnant girls themselves to earn money to contribute to their own support, and the sacrificial willingness of others to contribute time and services.

While the issue before us is complex, I would ask you to give particular attention to the following dimensions of the problem:

First, that current structures available for assisting a girl/woman who wishes to continue her pregnancy, lock her into the welfare ethic, and perpetuate her dependence.

Second, that there is a need to make a productive use of the waiting time during the months of pregnancy through programs of education and job training, since for many, these months become merely a time best described as "being in a holding pattern."

Third, that funds for infant care services be allocated to provide noninstitutional environments through the use of local "surrogate grandmothers."

Fourth, that funds be allocated for programs which provide counseling services of a more specialized nature which recognize the particular needs of the various types of females with problems pregnancies. Those who are (*a*) teenaged and single, (*b*) teenaged and married, (*c*) over 21 and single, (*d*) married/separated/divorced, (*e*) married/low-income/unemployed husband.

Fifth, that popular family planning programs be reevaluated with consideration given to programs which do not isolate the reproductive processes from a woman's whole being, which do not place primary emphasis on the mechanics of family planning in isolation from the motivation for family planning, and which do not see the pregnant female in isolation from those involved in her situation—the unborn child, the father of the child, and her parents if she is a minor.

Less than a week ago, the largest newspaper in south Jersey carried an article entitled "Teen Pregnancies on the Rise in Jersey." A spokesman for the New Jersey Department of Health said that schools' sex education programs "do not appear to be overwhelmingly successful." We could not agree more.

Surely all of us want our young people to be able to face the problems and decisions of life equipped with accurate information and the assurance of caring support. The development, promotion, and coordination of supportive services could provide the much needed means whereby individuals could solve their own problems with dignity, maturity, and independence.

And I thank you.

The CHAIRMAN. All right. Thank you.

Next.

Ms. BLOCKWICK. Thank you, Senator Williams. I am Jessma Blockwick, director of the department of population, United Methodist Board of Church and Society.

I appreciate the opportunity to appear today before you to make some comments on this piece of legislation.

We are very happy that the Department of Health, Education, and Welfare and the Congress are taking such deep concern on these issues on adolescent sexuality and pregnancy.

In general, we are very supportive of these initiatives but I would like today to comment on a few of the gaps of low priority which we see in this legislation.

One overall comment that I think others have made is the confusion there seems to exist between the initiatives under Senate 2910 and the new emphasis on teenagers in other legislative programs this year, particularly under Title X. I think we want to be sure that we are going to expand services rather than to duplicate—or put them in competition—of what these different pieces of legislation are going to accomplish specifically needs to be more clearly spelled out.

One of the areas in which none of these pieces of legislation on which we are speaking today deal with adequately is the area of family life and sex education. This is mentioned somewhat in passing in section 102(b), and this is an area which may be included, but it seems to us that it should be a very integral part and specifically spelled out that the legislation must include family life and sex education.

As others have commented here today, our society constantly bombards its teenagers with titillating aspects of sex whether it be television, movies, advertisements, printed media, are constant factors which push early sex activity. Yet, somehow, our values have become so obscured that what we cannot mention is the idea of waiting or of taking precautions. I think recently in the news there was a story about a television writer who left a program because he was not allowed to

have teenagers discuss the idea of pregnancy prevention, but it was all right for them to have sexual relations.

I notice that we are also shocked about the idea of contraceptive advertising on television and, yet, few people seem to be that concerned or know what to do about the idea of immediate gratification or desires, even violence sometimes.

I notice Dr. Sol Gordon will be speaking late this afternoon, and in my testimony I quote some of his writings in which he points out that even many of the social object studies which the United States is very big on may help to push the young people into early sexual activity. When you do a study, you publish it without any other context and say something like 7 out of 10 teenagers at a certain age are sexually active, it tends to have the effect of making the other three think, well, what is wrong with me, am I normal, do I have to get with it? And he points out we have perhaps been, even scientists have been too value free.

This legislation speaks about linkages and community outreach. I would hope that one of the community resources, which might be included in the networks, is some of the work which churches are doing in the area of family life and sex education which could deal with sexuality in the context of whole personhood and how to use sexuality wisely and carefully.

Of my own denomination, the United Methodist Church trains and certifies leaders in human sexuality. I would like to point out one of the emphases in that program is trying to develop ways of encouraging dialog between adults and teenagers, which has also been mentioned today as one of the problems of inability of communicating on these problems, so that teenagers are left on their own.

Perhaps if this legislation has a stronger emphasis and trust on family life and sex education, we ought to think in terms more than simply dealing with the young woman. One of the elements that perhaps should be included are intergenerational kinds of counseling and education.

I would also like to suggest that the legislation needs more clarification again on what is meant by preventive services. Does this simply mean delivery of contraceptives and access to information about contraceptives? The prevailing social climate of denial, avoidance, ambiguity, and taboo that surrounds adolescent sexuality contributes substantially to poor contraceptive use. It is difficult for the young to act responsibly without guidance.

Again I did hear of a model of a church in the suburban area outside of Washington that, during certain hours of the week, becomes a counseling and family planning clinic where young people can go in a nonthreatening atmosphere. Many of them have encountered sex education classes in school, but that does not seem to meet their needs of dealing with their whole personhood.

One particular aspect in preventative services that I have not seen in legislation and I have not heard this morning is the need to include male teenagers. The male adolescent is not mentioned in this legislation. Somehow there is the unstated assumption that the problem and responsibility fall only upon the adolescent young woman. I think this legislation offers an opportunity to end this kind of double stand-

ard and to help young men deal with their own sexual practices and their responsibilities for preventing pregnancy.

Even the pill, in some ways, makes it easier for the young male to feel uninvolved in pregnancy prevention. If something goes wrong, it is the girl's fault. Studies have shown that fears about the consequences of unprotected intercourse is really uncommon among young males. We surely do not want these governmental programs to imply encouragement for male irresponsibility by aiming all of the efforts at the young women alone.

The ability to plan on childbearing and spacing of children has been truly liberating for women. As they accept roles of greater responsibility within society, then surely men ought to accept responsibility for their sexual activity and to participate in the prevention of unintended pregnances. There are some models, few models, around the country because I think this has been a too long neglected area. I think the first purely male family planning and counseling clinic was in San Francisco, opened in San Francisco about 4 years ago. So we have a long way to go but it seems to me that this legislation could be one that encourage that kind of emphasis. And, course, after childbirth, too, these efforts should include the young man as much as possible because his life and his career plans can be totally upset if he does want to take responsibility for the baby he has fathered.

I also would like to suggest there needs to be more clarification on the definition of comprehensive services. Another witness earlier pointed out that this is one of the State services, the legislation mentions offering vocational and employment counseling. But that might be of little use to either the young mother or father if we do not take a look at the availability and access of day-care services for the child.

I think one fundamental part of any definition of comprehensive services has to be presenting the adolescent with a full range of options. Without choice there is no responsible decisionmaking in the matter of child bearing. Present adolescents need to have counseling on access to all of the options which range from abortion, to adoption, to keeping a child.

Our denomination is well aware of the sad nature of abortion, but we do believe that there are tragic conflicts of life with life, which sometimes makes abortion most acceptable among a series of painful alternatives. And many of the most unhappy in these situations involve teenagers; situations of statutory rape, very often of incest, and pregnancies of virtual children. Children who are pregnant, are themselves children.

As you know, teenagers account for one-third of all legal abortions applied in the United States. We work on this issue largely through the religious coalition for abortion right which now consists of 28 national denominations and organizations. All of them clearly affirm the responsibility and joy of parenthood, and much prefer alternatives as it were to abortion, the prevention of conception, the understanding of human reproduction, and the use of enlightened measures to control conception.

Many of these religious groups are leaders in efforts to improve understanding of human sexuality and of family life but, nonetheless, we believe firmly in the option of legal abortion must be safeguarded for all women.

We think that this legislation should be improved by the inclusion of services for early pregnancy detection, which also has not been mentioned, and appropriate counseling and services.

One last thing, Mr. Chairman. Clearly what a lot of witnesses and what I am talking about have to do with values in this whole area, and I would think that any counseling programs could deal with responsibility, which speaks to values, but I would like to lift up the fact that some of the comments which I have read about in this legislation implied that the Government will be dealing—moving to deal with questions of moral and religious values. I think this does give us some concern that Government might begin to set what our religious and moral values should be in regard to sex.

So, again, I would stress that it seems to me in the outreach, in the linkages that I talked about, these kinds of questions probably rest with individuals within the community groups and with religious organizations. I think this legislation provides many opportunities for cooperation between the administration, between the providers and the community groups, such as religious organizations.

In summary, we commend the work on this legislation, but it could be improved and clarified in some cases and strengthened in a number of others.

Thank you.

[The prepared statement of Ms. Blockwick follows:]

TESTIMONY OF

JESSMA BLOCKWICK

DIRECTOR, DEPARTMENT OF POPULATION

BOARD OF CHURCH AND SOCIETY

OF THE

UNITED METHODIST CHURCH

BEFORE THE

SENATE COMMITTEE ON HUMAN RESOURCES

ON THE

ADOLESCENT HEALTH, SERVICES, AND PREGNANCY PROTECTION

CARE ACT OF 1978.

S. 2910

July 12, 1978

Thank you, Mr. Chairman. I am Jessma Blockwick, Director of the Department of Population, of the United Methodist Board of Church and Society.

I appreciate this opportunity to respond to the programs proposed by S. 2910. We commend the Department of Health, Education and Welfare and the Congress for recognizing the seriousness of the problems related to adolescent sexual activity, pregnancy, and parenthood. The United Methodist Church has had a long-standing commitment to the health and well-being of individuals and families and to responsible parenthood, and is therefore deeply concerned with these same issues.

In 1976, the General Conference of the United Methodist Church, in a Resolution on Responsible Parenthood, recommended that both churches and the common society work to:

1. Provide to all education on human sexuality and family life in its varying forms, including means of marriage enrichment, rights of children, responsible and joyful expression of sexuality, and changing attitudes toward male and female roles in home and marketplace.

2. Provide counselling opportunities for married couples and those approaching marriage on the principles of responsible parenthood.

3. Make information and materials available so all can exercise responsible choice in the area of conception controls. We support the free flow of information on reputable, efficient and safe non-prescriptive contraceptive techniques through educational programs and through periodicals, radio, television and other advertising media. We support adequate public funding and increased participation in family planning services by public and private agencies, including church-related institutions, with the goal of making such services accessible to all regardless of economic status on geographic location.

Our faith tells us (in the Social Principles of the United Methodist Church, adopted in 1976) that "sexuality is a good gift of God, and we believe persons may be fully human only when that gift is acknowledged and affirmed by themselves, the church, and society." How this good gift is understood and used is determined more by attitudes and feelings than by factual information. Emotional factors such as a need for intimacy, and a sense of self worth, sex anxieties and peer pressures, sex roles as shaped by society, skills in inter-personal relationships and basic value commitments all play a part in shaping sexual behavior. It is during the growing sexual awareness of adolescence that these factors particularly shape attitudes and activity.

Statistics tell us that our society has not succeeded in dealing effectively with adolescent sexual attitudes and behavior. As you know, there are an estimated 11 million sexually active teenagers, many of whom seldom or never use contraceptives. Each year one million teenage girls become pregnant. Two-thirds of these pregnancies are conceived out of wedlock, and in recent years 27 percent were terminated by induced abortions. Each year, 600,000 women under the age of 20 give birth each year. Since most teenage pregnancies are unintended, in principle they should be avoidable. Clearly, our society needs to do a better job of communicating the meaning of the responsible use of sexuality to children and to teenagers.

For these reasons, we welcome the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978. We have, however, some questions and concerns about the legislation, and feel

that as it is currently drafted the result could be an insufficient and haphazard provision of low quality services.

The Department of Health, Education and Welfare has stressed that there is a double emphasis for this new teen pregnancy legislation: (1) to prevent unwanted pregnancies and (2) to provide services to already pregnant adolescents and subsequently to the teenage mothers and their babies. The provisions of S. 2190, however, seem aimed primarily at the latter objective.

This bill is a portion of a larger program that the Administration is advocating--$60 million for the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978 and $82 million for proposed expanded services under Medicaid, Title X, Community Health Centers and other existing programs. The authorizing legislation this year for Title X has placed an important emphasis on teenage pregnancy and includes recommendations for increased funding for preventive services. The relationship of Title X and S. 2910 needs to be clarified. Will family planning services for adolescents be duplicated or expanded by this new legislation? What is meant by "linkages" between the various services to be identified or provided?

1. THE NEED TO INCLUDE FAMILY LIFE AND SEX EDUCATION

Family life and sex education--an area which neither bill covers completely--should be one of the major thrusts in the attempt to prevent unwanted pregnancies and births. Our denomination, in affirming the principle of responsible parenthood, states that "the family in its varying forms constitutes the primary focus of love, acceptance, and nurture, bringing fulfillment to parents and child. Healthful and whole personhood

develops as one is loved, responds to love, and in that relationship comes to wholeness as a child of God." To develop such wholeness, we believe a child should be wanted, and should be born into an environment conducive to realization of his or her potential. This takes some considerable degree of maturity and stability and understanding on the part of a father and mother of what parenthood entails. We believe programs to build such understanding should be a specifically-spelled out part of this legislation. Section 102 (b) says that services which may be part of projects include "education at the community level concerning sexuality and the responsibilities of parenthood." We would like to see this language strengthened and this type of education made a more integral part of the whole program.

Our society constantly bombards young people with the titillation of sex; our media--television, movies, advertisements and printed materials of all kinds--push toward sexual activity. Yet, somehow we have so skewed our values that our definition of what cannot be mentioned publicly is the idea of waiting, of being responsible, of taking precaution to prevent pregnancy. We are shocked by the thought of contraceptive advertising or even sex education on television, but passively accept programs which encourage instant--even violent--gratification.

Dr. Sol Gordon, of the Institute for Family Research and Education, Syracuse, New York, and one of the best-known writers on teenage sexuality, has pointed out that scientific study without any value component may itself have been a factor in

pushing young people toward early sexual activity. He wrote:

> Those of us who are involved in research have a responsibility to go beyond simple statistics and clinical impressions. Providing only numbers and percentages sets up artificial standards of "performance" by which people can "grade" their sexual life style....As researchers, we have both philosophical and ethical responsibilities. When we talk about outlets, or about how many partners a person has had, without addressing the whole relationship between the partners, we lend credence to the curious kind of turn-on in which a body part substitutes for the whole person. ....We as professionals do a disservice to young people when we do not explore the meaning of sexual behavior and feelings. Do we then encourage them to rush at an early age toward the image they have of the "normal" teenager's sexual experience? By setting up familiarity with sex as an extremely important rite of passage without which one will forever remain a child, we tend to make it difficult for the average teenager to delay, to say no...The result is to support the pressures that propel young people to early and unprotected intercourse.

I hope that in an expanded emphasis on education for responsible expressions of sexuality, one of the community resources which could be included in these networks would be the churches and synagogues, which in a non-threatening mosphere can help to place sexuality in the context of whole personhood, a gift to be used wisely and carefully.

Sex education has a moral as well as a biological dimension. We need to discuss what it means to love

and care for one another. To trust and be trusted. We should raise the questions central to all human relationships. What is selfishness? Loyalty? Character? What does it mean to be loved or to be used?

As an example of this type of emphasis, the United Methodist Church trains, certifies, and supervises leaders in human sexuality who are then resources to local churches. Structured weekend experiences are held in local churches in which both parents and youth are involved. The foundations are laid for continuing dialogue within the family. Sexuality programs focus on the personal responsibility for one's behavior as a child of God while affirming sexuality as the expression of one's total personality, of one's femaleness or maleness.

The goals of these training programs are:

1. To grow in understanding and acceptance of sexuality as part of God's plan for human beings.
2. To expand knowledge of physical, emotional, and

spiritual aspects of sexuality.

3. To practice communication skills needed to talk about sexuality.

4. To examine various cultural standards while discovering guidelines for sexual identity and behavior consistent with a Christian lifestyle.

5. To look at interpersonal relations with a growing understanding of Christian love as a basis for constructive decision-making.

We suggest that the many programs of churches and synagogues dealing with ethical and moral values in this whole area could be an important component of the community outreach envisioned in this legislation. It is important that an emphasis on education be more clearly spelled out.

2. THE NEED TO DEFINE PREVENTIVE SERVICES

An allied question which needs additional clarification is what is meant by preventive services in this legislation. Are they simply services dealing with contraceptive education and dispensing? Do they include counselling and sex and family education as well? The prevailing social climate of denial, avoidance, ambiguity and taboo that surrounds adolescent sexuality contributes substantially to poor contraceptive use. It becomes difficult for young people to act responsibly about sex if they do not have rational and reasonable guidance. Further, when birth control services are difficult to obtain and when to admit contraceptive need engenders fear over possible discovery and retribution, avoidance and denial are inevitable. Hence, teen women become pregnant.

Here again, there are some church models for what prevention services might include. As one example, the Seat Pleasant United Methodist Church some years ago recognized the

need for a place where young women and men could receive free advice in a pleasant and confidential atmosphere about birth control, pregnancy, venereal disease detection; and set up the Prince George's Free Clinic. During clinic hours, Seat Pleasant Church undergoes a transformation: church school classrooms double as counselling rooms, a laboratory and office. The chapel becomes a waiting room equipped with radio, floor pillows, and a reading chart. A doctor temporarily "sets up shop" in the pastor's study, and the church office serves as the nurse's interview room.

Most of the patients are teen-agers, most have been sexually active for a short time if at all. Many have had some contact with sex education through the public schools, but are inadequately prepared to deal with their own or their partner's sexuality. These young people need help and advice, yet they rarely go to traditional agencies and are hesitant to talk about themselves and their sexuality, especially with their families.

Again, there is a need for preventive services which deal not just with biology, but with feelings, with values, with the whole person.

3. THE NEED TO INCLUDE MALES

In this legislation, the male adolescent is never mentioned. There is the unstated assumption that the problem and responsibility fall only upon the young adolescent woman. This legislation offers an opportunity to end this double standard, and to help young men deal with their own sexual practices and their responsibilities for preventing pregnancy.

In many ways, the pill has made it even easier for the male to feel uninvolved in pregnancy prevention. If something goes wrong, it is the girl's fault. Studies have shown that any fear about the consequences of unprotected intercourse is uncommon among males but common among the females. We surely do not want these governmental programs to reinforce the old double standard and imply encouragement of male irresponsibility by aiming efforts at the young women alone.

The Gospel makes it clear that Jesus regarded women and men as being of equal worth. Surely there has been no greater liberating force in the lives of women than the ability to plan the number and spacing of children they truly want. As women accept roles of greater responsibility within society, then surely men ought to accept responsibility for being sexually active and to participate in the prevention of unintended pregnancies. S. 2190 needs to emphasize quite specifically that programs should include education and counselling on the sexual responsibilities for the adolescent male. Programs designed to assist after the birth of a baby should strive to include the father also.

4. THE NEED TO MANDATE COMPREHENSIVE SERVICES.

A major assumption of S. 2190 is that what is needed is coordination of existing services; There are, however, substantial deficiencies in existing services and the needs of many teens are unmet. New and expanded services are therefore required, yet the definition of comprehensive services here is weak and vague. S. 2190 fails to specify a number of services which are particularly important in working with adolescent

pregnancy, such as infant day care, pregnancy testing, transportation to and from the service provider and personal counselling. Discretion of what should be provided is left almost totally to the provider, or to the DHEW administration. The need for comprehensive services is too great to be left so ill-defined in this legislation.

The adolescent women who chooses to give birth faces great social, economic and emotional risks. Unmarried teen mothers often leave school; they do not have job training; they face social disapproval, financial hardship. It is difficult to find work and adequate child-care facilities. The burden of caring for a child strains already fragile teen marriages, 72% of which end in divorce. For the teen-age father, accepting responsibility for a child can be equally devastating to life plans, yet we need to make it possible for them to accept their responsibility.

The Reverend Julieanne Hallman, a member of the United Methodist Board of Church and Society and a United Methodist minister, has found in her counselling with teen women that "they go through a birthing process within themselves. For the first time, they have to deal with what it means to be a women."

With comprehensive supportive services, the time of maternity and paternity; traumatic as it is likely to be at these young ages, can still become one of growth and healing.

One fundamental part of any definition of comprehensive services should be presenting adolescents with a full range of options. Without choice, there is no possibility of responsible decision-making in the matter of childbearing. Pregnant

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adolescents need to have counselling on and access to options which range from abortion to adoption to keeping the child.

Our denomination is well aware of the sad nature of abortion but believes that there are tragic conflicts of life with life that may make abortion the most acceptable among a series of painful alternatives. Many of these unhappy situations involve teenagers--situations of violent or statutory rape, or incest, of pregnancies to virtual children.

Teenagers account for one-third of all legal abortions performed in the United States--an estimated 325,000 abortions in 1975. In 1974, three in ten teenage pregnancies were terminated by abortion. About half of all teenage abortions were obtained by 18-and 19-year old girls; 45 percent by 15 to 17-year-olds; and 5 percent by girls 14 and younger.

Our denomination has worked on the issue of abortion largely through the Religious Coalition for Abortion Rights. The 26 national religious denominations and organizations of the Coalition have stated their affirmation of the responsibilities and joys of parenthood, and support increased efforts to promote voluntary means of fertility control and child spacing, as well as responsible programs of sex education. They believe that preferable by far to abortion is the prevention of conception through understanding of human reproduction and use of enlightened measures to control conception. They have long been committed to providing leadership in programs of education in human sexuality and family life.

Nonetheless, they believe firmly that the legal option of abortion, consistent with sound medical practice, must be preserved for all women, regardless of economic status. The

legislation we are considering today would be improved by the inclusion of services for early pregnancy detection and appropriate counselling and services.

Mr. Chairman, it is clear that many of the problems in this area we face today are not matters of more factual information of better contraceptive services. When we talk about responsible sexuality and of counselling, we are talking also about moral and ethical values. Some of the comments in regard to this legislation have seemed to imply that the government will be moving to deal with these questions of sexual values. While we believe education in values is crucial, we urge that such questions properly rest with individuals and with non-governmental organizations such as churches and synagogues. There are many ways through this legislation where cooperation between the administration, providers, and religious organizations is possible and desirable. Again, defining more clearly the exact nature of the terms used and services to be provided through this Act can help to clarify the appropriate roles for all the parties concerned.

In summary, I would like to emphasize once again our general support for S. 2910. We do, however, urge clarifying and strengthening this legislation. Our youth are precious. Adolescents are under many and heavy pressures as they seek to accept their sexuality and to integrate it within their developing identities. This legislation can do much to aid teenagers in this process. By doing so, the quality of life for individuals, the family, and the whole society will be enhanced.

The CHAIRMAN. Thank you very much.

In the area of education, the major imponderable still remains, and that is, how to approach bringing to young people the full understanding that we hope they will have, of pregnancy, and its implications, and meaning to them.

Do you know of any model where peer experience is included within an educational opportunity? We know in other areas of social concern, that peer experience is one of the most effective ways of facilitating the desire to understand, to know, to learn, and to act accordingly with that knowledge. Certainly, the programs that this committee has designed and supported have incorporated this principle and have been quite successful.

For instance take a social situation, where there is a problem in the health area of alcohol. We program resource money to institutional situations where the peer experience is one of the fundamental components to the program. It is very effective. There is nothing like the pontifical teacher who just does not have any appreciation what is on the mind of a youngster, but someone who has been through the situation and sensitive to the problem, might easily stimulate a desire to know more; and knowing more, perhaps be able to prevent some unwanted effects.

Is there a model in the educational system where there is a program like that?

Mrs. MECKLENBURG. Yes.

Senator Williams, might I comment on that?

Some comprehensive pregnancy services are located in schools. When this is the case there is interaction between the already pregnant girl, the staff, perhaps the young man who is involved, and other students in the school. Such interaction takes adolescent pregnancy out of the theoretical realm and brings it down to the very practical level for everyone. Students see what it is like to be a pregnant adolescent and what it is like to assume the responsibility of parenthood at this early age. These young mothers bring their children to the school for nursery services in the school while they complete their education. This also affords other students the opportunity to learn child development.

I recall a Life magazine article published a number of years ago that had a picture of a pregnant adolescent on the cover. A school support program for pregnant students was described and the effect that it had on the students, mothers, children, and the community was described. As I recall the school was in Orange County, Calif. Initially it might seem that the pregnant teenager would be rejected and ridiculed. But that was not the case. Rather, they received a great deal of empathy. But while they were understanding, most other teenagers could look at the situation and see what it would be like to be in that situation themselves. It became painfully clear what it was like to be 8 or 9 months pregnant and later to live up to the responsibilities of having and raising a child. The only caution I would have here is the necessity to guard against the mothers and their babies becoming demonstration projects. Their needs and feelings must be carefully considered.

In summary, I believe these comprehensive programs in the schools have achieved what you are looking for, Senator Williams.

The CHAIRMAN. Excellent. Excellent statement.

Senator Riegle, do you have any comments on the statements from the panel?

Senator RIEGLE. I simply would like to add a word to what you are saying about a peer example, the power of that kind of illustration. I hope a way can be found to see to it that we can help the teenagers in this way.

I gather you have all had an opportunity to testify. I appreciate your testimony. I am a strong supporter of the bill, though I worry about floating it in the face of the antispending mood that is overtaking the country and Congress at the present time.

In any event, let me thank all of you for your testimony. And if any members have questions for you, we will send them to you and let you respond in the record.

Ms. BLOCKWICK. Thank you.

Senator RIEGLE. Our next panel consists of Ms. Emily Palmer from my home State of Michigan; Mr. Clyde Shorey, Jr.; Dr. Adele Hofmann; Ms. Ilene Wolcott; and, in addition, we have Ms. Mildred Wurf from the Girls Club of America.

We have several committee hearings going on today, as you know. The Banking Committee upstairs is very much involved with new initiatives in terms of efforts to involve neighborhood and community groups in finding answers to urban problems. So several of us are shifting back and forth between committees today.

We are planning late today, and we may be interrupted by actions on the floor.

What I would like to ask you to do is summarize your statement as much as possible.

We will include the full statements in the record.

In order to make sure that each person has a chance to really hit the highlights that you have come to share with us, I would ask you to try to summarize in, say, 5 minutes or 7 minutes if at all possible.

We have another panel following yours, as you may know, so given that time pressure, I think that is the best way to do it.

We will start with Ms. Palmer. We are particularly pleased that you are here from Michigan and we welcome you.

STATEMENT OF EMILY PALMER, EXECUTIVE DIRECTOR, LULA BELLE STEWART CENTER, DETROIT, MICH., CHILD WELFARE LEAGUE OF AMERICA, INC., ACCOMPANIED BY CLYDE E. SHOREY, JR., VICE PRESIDENT FOR PUBLIC AFFAIRS, NATIONAL FOUNDATION OF THE MARCH OF DIMES; DR. ADELE D. HOFMANN, BOARD OF DIRECTORS, AMERICAN ACADEMY OF PEDIATRICS, WASHINGTON, D.C.; ILENE WOLCOTT, PROJECT DIRECTOR, WOMEN AND HEALTH ROUND TABLE, WASHINGTON, D.C.; AND M. WURF, GIRLS CLUB OF AMERICA, WASHINGTON, D.C., A PANEL

Ms. PALMER. Thank you, Senator Riegle. I was hoping you would be here.

I am Emily Palmer, executive director of Lula Belle Stewart Center in Detroit, a member agency of the Florence Crittenton division of the

Child Welfare League of America. Florence Crittenton has been serving pregnant women since 1883. The league is the national voluntary accrediting and standard-setting organization for child welfare agencies. Of the nearly 400 league agencies, 177 provide services to unmarried parents.

We commend HEW and Senators Kennedy and Williams for proposing a program to help this underserved poulation. We are concerned that the bill does not sufficiently recognize the complex nature of services to pregnant adolescents and, as currently drafted, could very well result in the haphazard provision of low-quality services.

Targeting the funds to services after conception is our first concern. Lula Belle Stewart Center, in keeping with national statistics, finds that 94 percent of the pregnant adolescents we serve keep their babies. We would like to see that this bill with its limited funding focus on providing services to pregnant adolescents and young parents. We recognize prevention as a critical component of the continuum of services. We urge you, however, to take advantage of expanded Title X funds for prevention programs.

S. 2910 addresses itself to the need for comprehensive programs listing many essential core services. However, the list is incomplete. Vital components of successful programs, such as residential and day care, are not given sufficient emphasis.

Teenagers cannot attend school or job training programs unless they are assured of quality day care. Nursery care for infants under 3 is practically nonexistent. The list of licensed family day-care providers is sparse. Many Crittenton centers, including ours, have developed their own onsite infant care services while parents attend groups and classes at our facilities.

Residential care is another key supportive service. Often, when a girl becomes pregnant, both natural and foster families are unable to cope, and need time to sort out their emotions. Alternative living arrangements become important. Following delivery, a family often expects the young mother and baby to begin independent living. Grandmothers may have full-time jobs, and are not anxious to begin anew the task of child rearing.

In the past few years, the Crittenton agencies have developed innovative approaches to meeting this need. Some provide apartment-type housing for mothers and babies. Lula Belle Stewart Center locates and licenses homes willing to take both a mother and her baby. Last year we had 34 requests, but could support only 11 placements. We recommend that the bill be amended to require that varied residential services be provided as a component of a comprehensive center.

Another needed service not addressed is transportation. Drop-in centers are a sound concept, but in large urban and sprawling suburban and rural areas, they may be inaccessible. Many of our classes are held in the late afternoon or evening. Safety, convenience, and motivation are factors in our decision to provide transportation. Although this taxes our resources, we would have no consistency in attendance otherwise.

Since many of the services are nonexistent or limited, "linking" would be of little consequence in building comprehensive centers. We recommend that the 50 percent limitation for services be increased to

75 for services and 25 for linkages. Last year, our center, with an annual budget or nearly $400,000, served 600 adolescents. In our county alone, 6,000 girls become pregnant every year. Lula Belle Stewart Center is supposed to serve a tricounty area.

Demonstration projects with declining funds are not in order. What is needed is an ongoing Federal commitment to provide services to pregnant adolescents and young parents.

In addition, the requirement for a 70-percent Federal contribution and 30 percent local matching funds should be lowered to 90–10. This would coincide with other family planning. The 10 percent should be allowed to be provided through "in kind" matching.

Other limitations lead us to believe that if the bill were enacted without alteration, few quality programs would be developed. The legislation lacks strong accountability provisions. Certain critical services must be mandated to assure that the goals of the legislation are achieved.

Additionally, standards must be attached to any funds provided. We recommend that language be added to the bill stating that:

All services funded in whole or in part by this legislation shall meet appropriate Federal standards and guidelines or the requirements of nationally recognized accrediting bodies for these services.

To further insure accountability, individual evaluations for each program and overall evaluation must be mandated. We suggest setting aside 3 to 5 percent of funds for evaluation. The lack of specificity in S. 2910 necessitates the establishment of an advisory council to work with HEW. The council should include experienced service providers from the social services, health and education field, as well as consumers or ex-consumers of service. HEW's Secretary should place the program under the Office of Human Development Services.

The legislation recognizes the need for technical assistance. We would like for this provision to include priority assistance to existing centers so that they can expand their operations and develop linkages.

There is an assumption in this bill that good intentions will create good services. We have spent hours with both Michigan and out-of-State groups working to initiate new programs, or expand existing centers. Groups will require considerable support to begin and run effective programs.

In conclusion, we would like to reemphasize our concerns regarding the vague focus of S. 2910. Comprehensive centers can effectively serve the pregnant adolescent, but the list of services must be complete and a higher percentage of the funds allotted to services.

Would these services be cost effective?

Program evaluations by LBSC and many of the other Florence Crittenton agencies indicate that many of the young parents we serve are assisted to return to school, enter job training, or the employment market, thus potentially reducing welfare costs tremendously.

A high percentage—85 percent at LBSC in 1977—of babies born to adolescent parents, who have been assisted by Florence Crittenton agencies to receive early and consistent prenatal care, deliver full-term normal babies, thus reducing the risk of added medical and institutional costs for these children.

How can we not afford to offer services to pregnant girls and young parents?

Senator RIEGLE. Thank you very much.

You did summarize your statement, and I want to assure you that the full statement will be made a part of the record, given this important testimony, which we appreciate.

[The prepared statement of Ms. Palmer and additional material supplied for the record follows:]

child welfare league of america, inc.

TESTIMONY
OF
CHILD WELFARE LEAGUE OF AMERICA
FLORENCE CRITTENTON DIVISION
BEFORE THE
SENATE HUMAN RESOURCES COMMITTEE

JULY 12, 1978

PRESENTED BY:

EMILY PALMER
EXECUTIVE DIRECTOR
LULA BELLE STEWART CENTER
DETROIT, MICHIGAN

STATEMENT OF THE
CHILD WELFARE LEAGUE OF AMERICA, INC.
PRESENTED TO THE
SENATE HUMAN RESOURCES COMMITTEE

JULY 12, 1978

I am Emily Palmer, Executive Director of the Lula Belle Stewart Center in Detroit, Michigan, an agency of the Florence Crittenton Division of the Child Welfare League of America, and a fully accredited member of the Child Welfare League of America. Florence Crittenton has been serving pregnant women since 1883. The Child Welfare League was established in 1920, and is the national voluntary accrediting and standard setting organization for child welfare agencies in the U.S. It is a privately supported organization devoting its efforts completely to the improvement of care and services for children. There are nearly 400 child welfare agencies directly affiliated with the League, including representatives from all religious groups, as well as nonsectarian public and private nonprofit agencies. One hundred seventy-seven (177) of these provide services to unmarried parents.

The Florence Crittenton Association of America merged with the Child Welfare League at the beginning of 1976, establishing the Florence Crittenton Division of the Child Welfare League. The major programs of the 35 member agencies in the Florence Crittenton Division are focused on comprehensive services to pregnant adolescents and young mothers and their infants.

The Lula Belle Stewart Center is a comprehensive center providing an array of services to pregnant adolescents, young parents, their children and families.

I come here today on behalf of the Child Welfare League in support of S. 2910, "The Adolescent Health Services and Pregnancy Prevention and Care Act of 1978." We commend the Department of Health, Education and Welfare, and Senator Kennedy for proposing a program to help this very underserved population. However, we are concerned that the bill does not sufficiently recognize the complex nature of services to pregnant adolescents and, as currently drafted, could very well result in the insufficient and haphazard provision of low quality services.

Targeting the funds to services after conception is our first concern. National statistics indicate that 90% of pregnant adolescents choose to keep their babies. At our center, the figure is 94%. In light of these figures and the continued expansion of federal funds for family planning services, we would like to see that this bill with its limited funding focus on providing services to pregnant adolescents and young parents and their children. We recognize prevention as a critical component of the continuum of services and believe that offering preventive services to a widely scattered population is a job in itself. We discovered that it was too cumbersome for our center to handle a prevention program aimed at the general high school population in combination with the range of services that we offer. A broad scale effort utilizing a large staff had to be mounted in order to reach a significant percentage of teenagers with information on prevention. We believe that

a comprehensive center cannot deliver all three phases of services unless it has an extraordinarily large budget. We now offer preventive services only to girls who are enrolled in our program. We would urge you to focus funding on programs offering services after conception while taking advantage of expanded Title X funds for prevention.

Pregnant adolescents and teenage parents do need a multitude of services. This group is not facing just one crisis, that of pregnancy. They are also experiencing many related decisions and life-changing problems. These young women are frequently from foster home backgrounds, and have a history of school, emotional and family problems. A number of Crittenton agencies report that as high as 75% to 80% of the girls come from foster care backgrounds. Any plan designed to "solve the problems" of adolescent teenagers must be sensitive to the numerous services needed to strengthen family life and prepare these adolescents for independent living.

S. 2910 addresses itself to the need for comprehensive program and lists many essential core services. However, the list is not complete. Vital components of successful programs such as residential and day care are not given sufficient emphasis. If young mothers are to be encouraged to stay in school, certain supportive services are critical. Teenagers cannot attend school or job training programs unless they are assured of quality day care for their children and infants. Nursery care for infants under three years is practically non-existent. The list of licensed family day care providers is sparse. Many Crittenton Centers have responded by developing their own on-site day care services for infants. At the Lula Belle Stewart Center, we offer day care while the

girls attend classes in our facility. We may have fifteen infants on any one day.

Residential care is another key supportive service. Often, when a girl becomes pregnant, her family is unable to cope with the situation. Both the girl and her parents may require time apart to sort out their emotions. Some families cannot tolerate the situation and will not allow the girl to remain at home. Many foster families are unwilling to deal with the tensions that teenage pregnancy creates. Alternative living arrangements become quite important for adolescents. In Baltimore, the Johns Hopkins Center, recognizing this need, utilizes the residential services of the Crittenton Center. Following delivery, a family often expects the young mother and baby to begin independent living. Many do not want to take on the responsibilities of the new family. Grandmothers may have full-time jobs. They are not anxious to begin anew the task of child rearing. After delivery is the time when support services are most needed. Ironically, this is frequently the time when the least amount of services are available.

In the past few years, the Crittenton agencies have developed various innovative approaches to meeting this need. Some agencies provide apartment type housing for mothers and babies. We operate a program of licensed foster homes for mothers and babies. Lula Belle Stewart is the only agency in the country locating homes which are willing to take both a mother and her baby. However, these types of residential services are offered on a very limited basis and demand far exceeds the supply. Last year, we had 34 requests for this specialized foster care service, but

could support only 11 placements. We also run a "crisis homes" program which locates temporary arrangements for mothers and babies following delivery. This allows the girls some breathing space to get back on their feet. We recommend that the bill be amended to require that residential services be provided as a component of a comprehensive center. This should include developing new facilities or supporting existing facilities for: (a) the pregnant adolescent, and (b) the mother and infant in a supportive environment for up to two years after birth.

Another needed service that S. 2910 fails to address is transportation. Drop-in centers are a sound concept, but in large urban and sprawling suburban and rural areas they may be inaccessible. We find that since the girls are in school during the day, many of our classes need to be held in the late afternoon or evening. But Detroit covers a large geographic area, and like many cities, has never developed an adequate public transportation system. It is also not safe for girls to travel on buses in the evening hours. We operate two vehicles to provide this much needed transportation component. Although this is very taxing on our resources, we would have no consistency in program attendance if we did not offer transportation.

These varied service components that are the responsibility of an effective comprehensive center illustrate the difficulty involved in setting up new programs. Linking services in order to offer an adequate program represents a constructive approach. However, since many of the services are currently non-existent or extremely limited, "linking" would be of little consequence. We recommend that the fifty percent limitation for services be increased to 75-services and 25-linkages. Most of the

Crittenton agencies provide the services, but funding limitations prevent them from offering help to all in need. Last year, our center with its annual budget of almost $500,000 dollars served almost 600 adolescents. Lula Belle Stewart was initially set up to serve the tri-county area of Wayne, Oakland, and Macomb. In Wayne County alone, 6,000 girls become pregnant every year. We are only able to work with ten percent of this population.

Lula Belle Stewart, other Crittenton facilities, as well as centers such as Johns Hopkins have demonstrated their effectiveness in lowering repeat incidence of adolescent pregnancy, and encouraging teens to be contributing parents. Crittenton centers in Toledo and Los Angeles report recidivism rates of 6% and 2% as compared to a national average of 25%. Demonstration projects with declining funds are not in order, particularly in the face of escalating need. What is necessary is an ongoing federal commitment to provide services to pregnant adolescents and young mothers. At least $60 million must be appropriated for fiscal year 1979, no less than $90 million for fiscal year 1980, and no less than $120 million for fiscal year 1981.

In addition to funding this program permanently at higher levels, the requirement for a 70% Federal contribution and 30% local matching funds should be lowered to 90/10. The 10% should be allowed to be provided through "in kind" matching, including donated space, goods or services. This would coincide with Title X, Title XX and other family planning programs. Many communities have little local funding available for starting new programs and scarce local tax revenues are under severe pressure

from competing interests. The Crittenton agency in Houston reports that private funds are extremely difficult to obtain in Texas.

Other limitations in S. 2910 lead us to believe that if the bill were enacted in its present form, few quality programs would be developed. The legislation lacks strong accountability provisions. If we are to have responsible agencies providing reliable and effective services, accountability is a must. S. 2910 enumerates an optional list of core services. If the aim of the legislation is comprehensive services in one center, or coordinated services linked together, certain critical services should be mandated to assure that these goals are achieved.

Additionally, standards must be attached to any funds provided under this legislation if federal funds are not to be used for questionable undertakings. We assure that all services offered meet high standards. For example, our center has hired a staff person who is responsible solely for licensing quality foster homes to assure that placements are successful. We recommend that language be added to the bill mandating service standards. This could be a provision stating that: "All services funded in whole or in part by this legislation shall meet appropriate federal standards and guidelines or the requirements of nationally recognized accrediting bodies for these services." Regulations could further detail such standards.

To further ensure accountability, individual evaluations for each program and overall evaluation must be mandated. We suggest setting aside 3 to 5 percent of funds for evaluation. We also feel that in S. 2910 the lack of specificity necessitates the establishment of an

Advisory Council to work with HEW to develop necessary evaluation criteria regulations to guarantee that the comprehensive focus be maintained. The Council should include experienced service providers from the social services, health and education fields. Additionally, we recommend that HEW's Secretary place this program under the Office of Human Development Services rather than under the Office of Population Affairs to ensure that the social services focus of the program be maintained.

The legislation recognizes the need for technical assistance to communities. We would like for this provision to be expanded to include priority assistance to existing centers so that they can expand their operations and develop linkages. There does seem to be an assumption in this bill that good intentions will create good services. We have spent hours with both Michigan and out-of-state groups working to initiate new programs or expand existing centers. In fact, we are now devoting a disproportionate amount of our time to this function. Groups will require ongoing and serious support to begin and run effective programs.

We commend the Committee for holding these hearings and recognizing the needs of pregnant adolescents and young mothers. We would like to re-emphasize our concerns regarding the weak provisions and vague focus of S. 2910. Comprehensive centers can effectively serve the pregnant adolescent. However, services must include day care and residential services, before and after delivery. A much higher percentage of the funds must be alloted to services or linkages will not develop.

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Would these services be cost-effective? Time and time again Congress has been presented with the data indicating that the incidence of low birth weight infants is twice as high among girls 15 and under than it is for all pregnant women. These smaller infants are 17 times more likely to be retarded or have cerebral palsy. The pressures that families must bear in bringing up handicapped children are tremendous. The costs in real dollars if they choose to institutionalize their children can run as high as $18,000 a year for the severely retarded. How can we not afford to offer services to pregnant girls and young mothers?

LULA BELLE STEWART CENTER, INC.

1534 WEBB AVENUE • DETROIT, MICHIGAN 48206
PHONE: (313) 867-2372

July 21, 1978

Honorable Harrison Williams
United States Senate
Room 352, RSOB
Washington, D. C. 20510

Dear Senator Williams:

I appreciated the opportunity to testify before the Committee on Human Resources concerning S. 2910. During the hearings, you requested witnesses to share models of effective comprehensive programs with the Committee. I believe that the Lula Belle Stewart Center in Detroit contains the components of a model program. I am enclosing a copy of a public affairs pamphlet describing our program (see pp. 14 & 15) as well as a program description with an updated supplement.

Please let me know if you have any questions about our center.

Sincerely,

Emily Palmer
Executive Director
Lula Belle Stewart Center

EP/bjw

THE LULA BELLE
STEWART CENTER PROGRAM

DETROIT, MICHIGAN

FLORENCE CRITTENTON ASSOCIATION OF AMERICA
67 IRVING PLACE, NEW YORK, N. Y. 10003

THE LULA BELLE STEWART CENTER

Detroit, Michigan

Excerpts from a descriptive report about the agency prepared by Miss Fannie Watson, Program Co-ordinator.

This material, describing the Lula Belle Stewart Center's history, service goals, methodology, staff functions, program design and expansion proposals, is used with permission of the author. Miss Watson, who holds the M.S.W. degree from the Wayne State University School of Social Work, has been with the agency since 1972.

FCAA is pleased to make this abridged report available to social agencies and other community institutions that are concerned about the growing numbers of teen-age single parents and their babies throughout the country. Their need for support and guidance in achieving self-hood and the capacity for responsible adult roles in today's world is fully documented in the story of Lula Belle Stewart Center in Detroit. This agency's program is a practical, realistic approach in providing services to adolescent parents in an urban setting.

Katherine Daly
Executive Director

LULA BELLE STEWART CENTER PROGRAM

1967 - 1974

HISTORICAL BACKGROUND

In response to the 1967 civil uprising in Detroit, many churches, community groups, and public and private social welfare agencies began addressing themselves to the needs of the "black community" or "Detroit's inner-City". It was obvious that the cause of the upheaval was not the planning of an organized group or the acting-out of deviant individuals. Instead, it stemmed from the deep-seated, angry frustrations of many individuals who lacked adequate services in the areas of housing, financial resources, medical care, employment, education, etc. Recognizing the void, existing agencies extended their service designs to tackle these problems. In addition, strategies were formulated to develop new agencies and services to meet the pressing needs of the families living in the area. Some agencies remained only temporarily, while others became permanent institutions in the community, including Lula Belle Stewart Center (LBSC).

The founders of LBSC were a cross-section of lay and professional people including teen-agers who were pregnant or had children. Their objective was to examine the services available to young, single pregnant teen-agers who planned to keep their babies. Statistics showed that in 1970 there were 10,840 births to single parents in the tri-county area (Wayne, Oakland and Macomb Counties of Michigan). Twenty-nine percent of those births were to mothers under 18 years old and the majority were in Wayne County. (Wayne County has a high density of blacks.) The committee found that there were many resources for white teen-age pregnant girls who wanted to place their children for adoption. On the contrary, the pattern in the black community had traditionally been to keep the child, and no single agency had attempted to deal comprehensively with the multitude of problems faced in single parenthood. (Interestingly, increasing numbers of single pregnant white women were also keeping their children; this behavioral change was presenting many challenging problems for the white community.)

In addition, the study committee became aware of racial implications with which it had to deal. There were many widely held myths about single pregnant girls, particularly in the black community. It had been thought that there was a subcultural behavior deviation here--that single parenthood was an accepted practice in the black community and prevention must relate to altering sexual mores.

The committee discovered quite the contrary. The typical single mother was very often an average young person, with no "character defects" who had been pressed by a variety of circumstances, frequently economic, into this difficult situation. Black families were universally traumatized by single pregnancy, and eventual acceptance of the pregnancy was a healthy response to an optionless situation, rather than an indication of approval or an absence of distress.

The committee's study concluded that traditional services had focused on the internal problems of supposedly deviant individuals rather than those external problems which lead to single unmarried pregnancy and which later make it impossible for young single parents to cope with life successfully. Therefore, the core problems weren't based on individual and family weaknesses but on socio-economic conditions in the communities where these

young people lived, which in turn are created by the inadequacy of a total society. There must be basic changes in these conditions; the mere "provision of services" does not solve basic problems.

The agency supporting the study committee was the United Community Services (UCS), an intermediary source that allocated funds collected by the United Foundation's Torch Drive, covering over 170 private agencies in Detroit's tri-county area. UCS became the funding resource for Lula Belle Stewart Center.

A basic resource document supporting the committee's findings was Andrew Billingsley's paper, "Strategies for Expanding Services to Negro Unwed Mothers".[1] Dr. Billingsley indicated that in 1968 there were no multi-service programs for pregnant school girls that encompassed all phases: pre-pregnancy, pregnancy, and post pregnancy, although each of these phases has its own particular hazards. He suggested that such a program should include the components of prevention, family planning, homemaker and child care services, and counseling individuals about options such as abortions or adoption. He also recommended provisions for economic, health, educational and social service needs of the young women, their boyfriends and their families; courses in family living; individual and group counseling; assistance in housing and financial aid; legal counseling, vocational aid and most importantly, the need to involve the single father.

Using Billingsley's concepts and the study committee's findings, the next tasks were to secure funds, find board members and locate housing facilities for an agency.

UCS responded to the need for service. The closing of the Florence Crittenton Maternity Home, which had been operating at 50 percent of its capacity, made way for the funding of Lula Belle Stewart Center. The maternity home had served mostly middle class whites and was located in inner-city Detroit. Its operating budget had been $249,000. UCS allocated $159,000 to LBSC for services to young single parents who were keeping their children. A few of the members of the predominantly black study committee became the core for a 23-member board of Lula Belle Stewart Center. These individuals had knowledge of the problem and a commitment to the cause. In addition, the board had the sole responsibility for hiring the executive director of the Center.

The Center's name was chosen to commemorate the memory of Dr. Lula Belle Stewart, Detroit's first black pediatric cardiologist. Married and the mother of three children, she had dedicated her 13 years of living in Detroit to working with black families in the metropolitan area, prior to her death in November, 1965. The intensity of Dr. Stewart's feelings for black family life had a lasting impact on the community she served, and the Center is a fitting monument to her beliefs. Her husband, Phil C. Robinson, a distinguished educator, has stated, "In a society where inhumanity to the poor and needy are the rule, Lula Belle Stewart Center stands as a glowing exception to that rule.

"The values and goals of Lula Belle Stewart permeate the entire scope of the Center's services. The responsibility of the strong, educated, fortunate few to reach out and open doors for the weak, unfortunate many, was one of her basic beliefs.

"Affectionately called Lula Belle by professional colleagues and laymen alike, the doctor was able to achieve an easy mode of communication with people, not because she worked at it, but because of her humanitarian nature and commitment to serving people. She understood the importance of transmitting a feeling to each patient of being special and personal..

"A many-dimensional woman, she wanted good health, freedom, beauty and a sense of personal worth and fulfillment for everyone and especially for the young."

Lula Belle Stewart Center is in the midst of the black community, readily accessible by city bus. While the Center serves three counties, covering a land space of 2,042 square miles, its primary clients are located in inner-city Detroit.

The surrounding area is a combination of mixed dwellings, including large apartment buildings with low-income families, large spacious homes of upper-middle-class blacks, and comfortable homes of older, retired blacks. The area homeowners are concerned about their neighborhood and maintain strong block clubs, which have made use of Lula Belle Stewart Center. Encompassed in this mixture are two medium-sized hospitals, one nursing home, a residential treatment center for adolescent boys, a Catholic high school, one public elementary school and one public high school. All of these institutions have been co-operative in working with the LBSC program.

The building that houses the Center is a large three-story structure. It was previously a medical clinic, with rooms that once served as examining rooms now converted to staff offices. Since the building also served as a residence for doctors, a kitchen, living room and dining room, are now being used for group sessions. Surrounded by a high fence with a large sign emblazoned with the agency's name and Torch Drive symbol, LBSC also has space for parking.

THE CENTER'S GOALS AND OBJECTIVES

Mrs. Emily Palmer, LBSC Executive Director, has formulated its goals and objectives:

1. To alleviate the situational problems confronting young, single parents in such areas as employment, child care, housing, health care, finance, family and interpersonal relations.
2. To conduct research into the conditions and circumstances which contribute to single parentage; and to disseminate information about the unsolved problems and service needs of single parents and their families.
3. To enable clients to obtain medical services and maintain good health.
4. To enable clients to continue their education during pregnancy and after delivery.
5. To assure that children are properly cared for during the day when parents are absent from the home.
6. To enable clients to obtain employment or job training where appropriate.
7. To enable clients to obtain financial assistance when necessary.
8. To build in supports that will maximize potential of each client as a parent.
9. To improve family and inter-personal relationships.

10. To make alternative temporary or permanent living arrangements for pregnant girls and young mothers with infants.

11. To help bring about any needed changes in the broader societal systems that tend to exclude rather than include single parents.

METHODOLOGY

The frame of reference in implementing the Center's program is the generic social work approach, using case, group and community social work. The intervention technique has been the life-space approach which works well because of the close contact between workers and among workers and clients at the Center. Staff deal with behavior when it is observed. For example, if deviant behavior on the part of a young mother toward her child is observed, a staff member intervenes on the spot, offering alternative ways of handling children.

System Theory principles also are utilized, to encourage staff not to view the client as an isolated entity. Clients are seen and worked with from the perspective of their individuality, their membership in a family, their membership in a small group and again in larger groups. Realizing the interlocking components, workers must:

1) assess the relationships within the systems and speculate on how they will affect change within any part of the whole;

2) pinpoint the crucial point where intervention techniques are likely to bring about the desired change;

3) determine the type of intervention to be utilized;

4) anticipate probable results of intervention on each level.[2]

Extensive work with the families of clients is a top priority at the Center. Workers observe family interaction to learn how family members receive and discharge feelings, and what attitudes and behavior patterns exist within the immediate family group. Family interactions are influenced by social environment and by the adult members' experiences in their families of origin. A worker examines the following aspects of family functioning:

1) family vulnerability and strengths;
2) family roles;
3) family goals;
4) family communication patterns;
5) family-need response patterns.[3]

The Center's staff consists of:

Executive Director (MSW)
Program Coordinator (MSW in Group Work)
Casework Supervisor (MSW)
Two social workers (MSW)
Four Case-Aides (BA)
One para-professional (High School)
Executive Secretary
Clark-Typist
Child Case Worker
Driver

School Out-Reach Worker (MS)
Male Out-Reach Worker for Single Fathers (High School)

CENTER'S PROGRAM DESIGN

Lula Belle Stewart Center became functional January 1, 1972, as a multi-purpose agency formed to address the needs of single, teenage parents. The program is designed to offer support to seven persons or more: the single mother and expectant single mother, single father, the child (children) of single parents, and the new or prospective grandparents.

The objective of the program from the beginning has been to provide practical help: food, clothing, financial assistance, shelter, medical care, education; and, counseling in interpersonal relationships, feelings and anxieties associated with single parenting. In addition, the agency addresses itself to the need for system change, dealing in alterations of those rules and regulations of schools, welfare departments, employment resources, juvenile courts, etc., which constitute obstacles for young single parents.

The Center has attempted to alter the understanding of the total community in order to generate increasingly positive support and assistance for single parents rather than the traditional, negative, judgmental, punitive approach. It was essential that the black perspective be brought to bear on the problems of single parenting as it relates to black families who would be served by this agnecy. The Center at the outset established a strong base for its staff to solve some of the problems that existed. Staff's frame of reference is the recognition of the plight and strength of blacks. The original staff was composed of seven blacks and five whites. The current staff consists of two whites and fourteen blacks. All university students have been black with the exception of one.

From January through May, 1972, the agency offered predominantly case-work service. In May, following the hiring of the Program Co-ordinator and Casework Supervisor, program activities introduced the group component. Although agency hours had previously been 8:30 AM - 4:30 PM, group activities expanded agency hours to 8:00 PM, two evenings a week. Presently The Center is open four evenings a week until 8:00 PM.

A psychiatrist has been used consistently as a consultant throughout the program. To better understand the dynamics of human behavior of the agency's consumer population, case staffings have been held once a month. The black woman psychiatrist uses a realistic approach in relating to the social pressures that affect the behavior of people, particularly black people. She represents the humanistic point of view which is an essential criterion for all who participate in the Center's program.

Staff meetings are held periodically to discuss in-house concerns. The purpose of the meetings is to allow staff to communicate as a whole on particular issues and situations. In order to maintain staff morale and develop a sense of staff cohesion, a social committee was formed to remember workers' birthdays, exchange Christmas gifts, etc.

In-service training has become a major component of staff training. This allows staff to express views, concerns, different methodologies, feelings, and attitudes towards the many variables relating to single parents. The consumers have been active in training sessions, often enlightening and

educating the staff on the trends of their peers in single parenting, sex education and family planning. Thus, the service design allows all people to play an active role in the helping process of the agency.

GROUP SERVICES

The purpose of each of the groups at the Center is to achieve the basic group work principle: the "development of the person toward his/her individual potential, improvement of relationships and social functioning competencies."

With this concept in mind, group activities were designed to meet the needs of young single parents in their day-to-day functioning. First, it was necessary to develop an atmosphere that allowed for free self-expression. Therefore, it was of great importance to consider such group components as: climate, cohesion, composition (size and individuals), norms, and structure. Of equal value were the program's content and the setting of the groups.

All groups have maintained a positive atmosphere and the Center has focused on maintaining an informal climate. Although individuals are not required to attend group sessions, six of the groups have developed a membership format with a great sense of cohesion. The composition of these groups is 95 percent female. The composition of five of the groups is similar in age range. Members have mutual interests and each of these groups is closed to new members. The size of the groups varies from 6 to 14 members. As a result of the informal setting, individuals within the groups are willingly accepting of one another with differences of opinions accepted, although sometimes challenged. All groups, with the exception of one, maintain an informal structure. Some group members sit on the Board of Directors, but they represent no particular power or influence among the agency's consumers.

In describing the Center, it may be helpful to note that all group activities are held in the lounge and dining room areas. The lounge is furnished in Early American furniture with a TV and record player. All rooms have carpeting and furnishings were donated by the maternity home that closed. The dining room has five small round tables, a buffet, and a book rack. Paperback books are supplied by the Detroit Public Library. A small kitchen is located between these two rooms. The agency purchases food so that the consumers may prepare snacks--hamburgers and hot dogs, etc. The clients are free to prepare food at will, as the staff realizes that teen-agers, especially pregnant teen-agers, have large appetites. All groups use many program tools ranging from role-playing to visual aids.

GROUPS

Parenting Skills: The purpose is to assist young parents in developing useful skills and knowledge of all aspects of child rearing. During the past two years, group leaders have been representative of the following fields:

Nutrition

1. General nutrition needs, five basic food categories.
2. Special needs of proper nutrition during pregnancy and its effects on offspring

3. Meal planning
4. Preparation of economical meals with good nutrition (lab session offered)
5. Shopping for groceries
6. Using commodity foods in cooking

Budgeting

1. Tips on shopping
2. Buying on installment plans
3. Door-to-door salespersons
4. ADC Budgeting
5. Comparison shopping
6. Buying wants and needs.
7. Credit

Child Psychology

1. Psychological and physical development
2. Use of discipline
3. I.Q. tests and cultural backgrounds
4. Parents as models

Mother and Baby Care (Registered nurses lead group.)

1. Prenatal care

   a. Clinics versus private doctors
   b. General health and hygiene rules

2. Childbirth and delivery

   a. Stages of labor
   b. Natural childbirth
   c. Caesarean section
   d. Premature birth

3. Hospital setting (using visual aids)

   a. What happens in labor room and delivery room

4. Post-partum care

   a. Visits to doctors
   b. General health and hygiene rules

5. Caring for infant

   a. Feeding
   b. Bathing
   c. Adequate clothing
   d. Observing behavior

Pediatrics (Physician leads group.)

1. Infant and early childhood immunizations
2. Illness in infancy and early childhood
3. Value of doctor's visits for children
4. Problems in children's eating habits
5. Child's identification needs for male and female modeling
6. Children and medication

Child Development (PhD Candidate leads discussion.)

1. Differences in children's growth patterns
2. The role of heredity and environment, its effects on child development
3. Infant and child appearance
4. Reflex action
5. Physical and motor growth
6. Personality and emotional development
7. Social and intellectual development
8. Language
9. Eating and feeding patterns
10. Love and security
11. Sleeping routines
12. Setting limits
13. Fear
14. Self-awareness
15. Exposure to other people

Creative Play

1. Use of play
2. Meaning of play
3. Making play objects from household items
4. Play and child development (this involves both mother and child)
5. Play as a tool for toilet training
6. Play as an educational process

Legal Aspect of Parenting (Attorney leads group.)

1. Legal rights and responsibilities of single fathers
2. Legal rights and responsibilities of single school age mothers
3. Birth certificates
4. Social security and the child
5. Marriage after the birth of a child

Child Abuse (Members of Parents Anonymous discuss characteristics of child abusers.)

1. Were often abused by their parents
2. The child represents a part of the parent that the parent dislikes in self
3. A lack of tolerance of child's behavior

Parents Anonymous Group

1. Counselling in above areas
2. Exchange of baby sitting service
3. An opportunity for parents to express their feelings towards children and self

Housing (Representative from public housing, landlord and tenants' rights groups lead discussions.)

1. Rent ceiling
2. Tenant contract to landlord
3. Security deposits
4. Tenants' rights
5. Eviction orders
6. Complaint of landlords by tenants--proper procedures

Domestic Technology (A woman skilled in general housecleaning demonstrates.)

1. Cleaning stoves
2. Cleaning refrigerators
3. Using shelf coverings
4. Washing and use of detergents

5. Cleaning floors
6. Making inexpensive household items (curtains, tablecloths, etc.)

Different components of the parenting skills sessions range from a minimum of two weeks to a maximum of three months. Lab sessions are part of the group design, often involving both parent and child when the subject matter calls for examples. From all indications, it appears that parents who have consistently made use of the group services have a healthy attitude towards rearing their children. This particular group is not a closed group and attendance varies.

Sex Education: This group is referred to as T.I.S.S. (Telling It Straight About Sex), the title of a book the agency uses for the group. The group maintains an informal atmosphere, and deals with human sexuality, as well as the anatomy of sex. A number of program-tools are used:

1. Speakers, specifically obstetricians, gynecologists, and public health workers, assist young people in understanding their bodies. The consumers ask questions of the doctors in a comfortable setting, while public health workers discuss the myths and realities of venereal diseases, using movies and books as aids.

2. Games are used to help young people in expressing their feelings, attitudes and values in the area of sexuality. Role-playing helps clients to act out interpersonal conflicts in which they are actively involved, including family conflicts or boy-girl relationships.

Discussions on conception and family planning, led by one of the agency's caseworkers, focus on the myths and reality of sex.

Movies are used to facilitate discussion in the area of teen-age male and female relationships. The agency uses two excellent movies, "Too Soon Blues" and "Chance of Love."

Career Time: Designed to assist the agency's consumers in educational counseling, educational financial assistance, General Educational Development, college admission and on-the-job programs, this group is led by a volunteer who has helped a number of young people from the Center become enrolled in college. Career Time's goal is two-fold: to increase the clients' options in life through education and to make the client economically independent of the welfare system through expanded job opportunities.

Charm Session and Personal Hygiene: The group is intended to assist clients in developing a higher degree of personal esteem through the use of beauty aids, grooming, and correct diction. This group is small and informal, with leadership by professional models and cosmetologists. Both young men and young women become actively involved in caring for their personal hygiene, with lab sessions in permanents, African hair styles, manicures, etc. The sessions seem to bear out the old adage "you'll feel better and act better if you look better."

Think-Thin is led by the director of casework staff. The group process is focused on mutual support in controlling weight, especially during pregnancy. It also encourages the girls to eat nutritious meals, including an occasional dinner out at a low-calorie restaurant.

Rap Sessions: The group leaders are a case-aide and a graduate student who help young single mothers develop a sense of self-awareness and to improve interpersonal relationships. Special emphasis is placed on the clients' role in society as single parents, their feelings as single parents, and their relationships with their parents prior to becoming pregnant, during pregnancy, and after delivery. Concepts of marriage and feelings regarding the child's father or the male figure in each of their lives are also discussed. The rap sessions use program media such as role playing, art, movies and group outings. Some of these tools allow for non-verbal communication, which often serves as a vehicle for expression during adolescence. Outings, for instance, allow group leaders to observe clients outside the agency setting and to note how group members deal with their environment. This group was closed to new members shortly after group cohesion was established.

Zodiac Club: The purpose of this small, closed treatment group of adolescent girls, 13-15 years old, is to examine the dynamics of younger teenage pregnancies. In rap sessions participants are encouraged to express their feelings under the guidance of a graduate group work student. Program tools such as bowling and crafts are used to develop personal esteem and positive feelings of accomplishment. In addition, dinner, movies and picnic outings allow the worker to observe members outside the group environment. Assessments of this group to date indicate that the participants: 1) lack knowledge of sex education; 2) resent the responsibility of caring for a child; 3) feel it is important to date "older" men (22-30 years) after delivery, since they are not accepted by teen-age boys in their peer group setting, even though pregnancy resulted by boys their age.

Young Adult Group: This group is led by the program co-ordinator of the agency. The group assists young women 18 years and older to deal realistically with some of the problems they face. Obviously, the problems of young pregnant adults are significantly different from those of younger pregnant girls. Socialization activities requiring adult legal status (e.g., weekend trip to Toronto and other parties) are organized.

Group discussions focus on employment, personal finances, heterosexual relationships and independent living. Magazine articles, newspapers, and books often provide the impetus for many of the discussions.

The original group of fifteen persons entered the program with all of the attendant problems of young pregnant unmarried black women. As a result of the program, each departing member has left with a new sense of direction and some basic coping skills. For example, one young woman is now married and a college graduate; another is a graduate student in the School of Social Work; one works as an accountant; and four are under-graduate students.

Sewing: The purpose of this group is to help clients use sewing as an economic tool, while developing a sense of accomplishment by completing a task. The group's leader, a retired seamstress, not only provides clients with excellent training in clothing repair and alteration, but also displays the sensitivity and guidance needed by this group.

Parent's Group: Led by group work graduate students, this group's purpose is to allow parents of the Center's primary clients to ventilate their mutual concerns as grandparents or prospective grandparents and to deal with those concerns realistically. It has been difficult to form such a group because the parents have resisted the idea. However, this is an integral part of the agency's total program.

Advisory Council: The Advisory Council is a small task-group composed of nine people. A graduate student, studying community organization in the School of Social Work, is the group leader.

The purpose of the Advisory Council is to develop policies and act as advocates for the agency's consumers. This task-oriented group has the following responsibilities:

1. to make recommendations to Board and staff concerning program and policies;
2. to involve the Center in community projects;
3. to work with individual community leaders;
4. to address itself to the problems of single parenthood;
5. to raise monies for the clients' emergency fund (e.g., fees for apartment security deposits, tuitions, etc.);
6. to serve as advocates for policies which will maximize opportunities for young single parents.

Although council members have not become active in all of the above areas, they have had input into agency-sponsored programs such as the Christmas Program. The group has reviewed and made recommendations for a future agency group home, and decorated the agency's nursery. One small fund raising effort, a bake sale, held in a neighborhood school, was successful.

The group is beginning to recognize the need for community involvement. However, these are the same young women who suffer the anxieties of being single parents in a two-parent oriented society. They are in the process of developing the skills to implement the changes needed in our society for young single parents.

SUPPORTIVE SERVICES

Public Relations Consultant: The professional public relations consultant role was to establish a communication network between the community and Lula Belle Stewart Center. The staff, board and consumers appeared on TV talk shows and radio programs, while newspaper articles featured the Center and its success stories regularly. The purpose was to educate the community concerning the problems of single parenting, secure referrals, seek volunteers and request donations of various items for our consumers. The public relations consultant is still active with the Center and her work has been most meaningful in creating positive support for its work.

The response was overwhelming and referrals came from many sources: doctors' offices, medical clinics, courts, schools, the media, and word-of-mouth. At the end of the first year LBSC had served 561 individuals.

Agency Newsletter: Once a month the agency's newsletter is mailed to over 300 readers, including clients and social service agencies. The purposes of the newsletter is to communicate agency activities, give information from parenting skills sessions, offer grooming tips and describe new services affecting clients. A daily calendar of events for the month is also included. A single mother-client prepares the newsletter and is paid for her services.

Agency Transportation: When group activities began attendance was low. In assessing the situation, it was concluded that transportation was a major problem. As mentioned earlier, the agency serves a tri-county area encompassing 2,042 square miles, but the consumer population is predominantly from inner city Detroit.

The agency purchased a 12-passenger station wagon. A para-professional man worker became group leader and driver, and attendance patterns improved markedly. The Center currently has a full-time driver.

The agency also makes a practice of purchasing DSR bus tickets for individual use. These are distributed to clients who are in need of transportation to seek jobs, apply to the Department of Social Services, visit medical clinics and attend school.

Volunteers: As news of the agency's program and referrals increased, so did the numbers of volunteers--representing a broad spectrum of skills and expertise. Orientation sessions are held regularly for these volunteers.

Emergency Homes: In an effort to increase community participation, the Center has solicited volunteers to offer their homes as emergency shelters for young pregnant women. It is often necessary for girls to leave their homes during crisis situations, usually when the pregnancy is discovered by the parents, or after the baby arrives home from the hospital.

Each volunteer home is rigorously screened. The criteria used are the size of the home, the individual volunteer's life style, the motivation for volunteering, and the volunteer's feelings about children and single parents. Selected homes are then used as emergency shelters until a more permanent plan can be made for the clients. So far, over 20 homes have been involved.

Swap Shop: Originally intended as a place where young mothers could "swap" outgrown children's clothing for more current sizes, the Swap Shop was also planned to stimulate involvement by the community. In donating goods to the Shop, members of the community would hopefully become more aware of the agency's services and educated to the problems of single parenthood. The Shop became such a success that the agency had to seek storage space outside its building. In addition to clothing for infants and children, donations of baby furniture, household supplies and clothing for the young women and young men were also received.

The response of community groups has exceeded all expectations. Church groups, sororities, social clubs, etc., have given baby showers for Lula Belle Stewart Center. Girl Scout troops and the Camp Fire Girls have made baby clothes. At Christmas time all of the above groups provide services and gifts.

Nursery: After eight or nine months of group activities, it was essential that a nursery become part of the program. A large room on the first floor was remodeled into the nursery by the Advisory Council. A child care worker was hired to take responsibility for the children while the parents are in the building.

The nursery also serves as a growth and development center for the children. Tools and toys are used to stimulate motor development, while games and songs are encouraged to create a learning experience for each child. The child care worker is responsible for observing children's development, as well as any signs that might indicate unhealthy development, such as child abuse or neglect.

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Socialization Activities: The agency involves the total client population in a variety of activities in order to allow staff to become better acquainted with them outside the agency structure, through home calls and contacts with other social service agencies. The activities also give the clients better insight about the people who work with them.

Winter activities include theater parties, special events, and cultural activities, such as the African Ballet. Clients are encouraged to bring dates to all activities.

During the summer months clients visit amusement parks, beaches and rock concerts. Children accompany their parents on all outings except rock concerts. The agency provides bus transportation and prepares the food.

Obviously, some activities have greater attendance than others. In all cases, clients have the option of selecting the entertainment and the cultural exposure they feel will be most beneficial to them.

EXPANSION OF SERVICES

Pilot Project--Detroit Public Schools: Since Lula Belle Stewart Center operates as an outreach program, it is essential to go where potential clients are, the schools. In the Fall of 1972, a contact was made with the Deputy Superintendent of the Detroit Schools to request the Center's participation in the schools. The request was readily accepted and LBSC began intake in two inner city high schools.

Since most of the pregnant girls were unaware of the Center's services, staff began by visiting classes, explaining the program, dispelling the myths of human sexuality, and suggesting that if students had personal concerns and wanted assistance staff would return to the school on certain days to see them. Notices were also put in teachers' mailboxes and announcements were made in each class.

The intake workers were given a room where privacy could be maintained. Rapport was easily established with the teachers who were very supportive, with positive results.

The Center's staff, during the past two years, have served fewer than fifty white persons on an individual or group basis. However, they are constantly filling requests to address the mainly white suburban schools. LBSC staff expertise in family planning and sex education is being sought throughout the tri-county area. People from social service agencies across the country come to the Center requesting information about services, and ways in which such services may be implemented in other cities.

Lula Belle Stewart Center, Eastside Project: The City of Detroit is divided into east and west by Woodward Avenue. In many people's opinion, that division extends beyond geography to create two different social climates.

The eastside was a settling place for ethnic groups such as Italians and Poles in the beginning of the century. These ethnic groups established centers and settlement houses to help residents adjust to their new surroundings. After becoming socially and economically secure, these ethnic groups moved away, and were replaced by blacks who had migrated

from the South around World War II. The eastside became the pocket of lower-class black life and the area became known as the "Bottom." Blacks made use of the settlements and centers left by other ethnic groups until the "bottom" was replaced by expensive highrise apartments now occupied by middle-class blacks and whites. This urban renewal, with its resulting family dislocation, high rates of unemployment and lack of equal education has left eastside family life in a state of flux.

A suburban agency serving single parents requested the Center's assistance in the development of an outreach program on the eastside of Detroit. The agency supplied one worker. An eastside church provided the facility to house the group activity.

The program began in March, 1974 with two groups, T.I.S.S. and Rap Session on the eastside. Staff members made arrangements to speak to teenage groups, block clubs, older adults, and parents who had preschool as well as teenage children. Staff also made use of eastside schools by speaking to classes.

The two groups (T.I.S.S. and Rap) have been well accepted and attendance has been good. Eastside staff uses the same format as the Center itself. The eastside groups have had more involvement of young men than the Center on the west side, perhaps because eastside youth are oriented more toward group activity than westside youth.

Group Home: The agency is currently in the process of trying to establish a group home for young single mothers (last year there were forty requests for services of this type).

The home will house only ten persons, including infants and children. Depending on the individual needs of each case, young single mothers will be able to live in the home for periods ranging from 24 hours to one year. The purpose of the group home is to provide emergency housing, and to help young single mothers to increase their ability to parent. The group home will provide a more structured setting than emergency homes. Most emergency homes only allow for a 2-week maximum stay for minors. One volunteer allows older girls to stay longer periods of time (two months or more) and some emergency homes have obtained foster care licenses to allow minors to stay longer.

DCS has approved the group home concept, and it is hoped that the home will become operational by 1975.

CONCLUSION

The experience of working at Lula Belle Stewart Center prompts the following observations:

1. It is ridiculous and sad that young men and women in their teens lack adequate knowledge about sexual matters. The Center was not established for the prevention of pregnancy. Nevertheless, it is healthier to prevent something than to deal with the aftermath. Therefore, sex education must be an essential element of the Center's program.

2. It is still more absurd that legislation cannot support a sex

education requirement as a fundamental part of the educational curriculum. Lula Belle Stewart Center is in the business of educating and advocating for a minority population--the single parent. It must therefore remain ready to challenge the existing welfare laws, and to beat back any genocidal philosophies that recommend sterilization of certain females.

3. Lula Belle Stewart Center is in business to offer young people options as to what they will make of their lives--options which heretofore have not existed for single parents.

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SUMMARY OF SERVICES OFFERED
BY
LULA BELLE STEWART CENTER

The Lula Belle Stewart Center provides services that assist young, low-income, single and expectant parents.

Services include individual, conjoint; family and group counseling. Concrete service is provided through lingages with other community resources through which we enable our clients to obtain pre-natal and other medical care that includes well baby care, housing (both temporary and permanent), day care, employment, job training, financial assistance and continuing education.

Lula Belle Stewart Center is a community outreach program and as such services are provided through home visits as well as office contacts. A strong component of the program is community involvement and co-ordination of existing community resources.

A variety of group activities are provided at the Center in order to promote self-awareness, increase parenting skills, develop self-direction and education in areas of everday living. Parenting skills courses are designed to provide young parents with skills necessary to nurture and rear children, offers information on nutrition; meal preparation, child care and development. Other groups are conducted to increase knowledge in the area of human sexuality, including contraceptive information.

Group therapy is also provided through skilled professional leadership for those young parents with deeper emotional problems. In the area of continuing education, an alternative education program is operative at the Center through co-operation with the Detroit Board of Education. The Board of Education provides teachers and educational supplies. LBSC provides a nursery with trained Child Care Workers for the infants who must come to class with the parent and transportation. The alternative education program at LBSC which includes basic remedial education and preparation for the G.E.D. (General Equivalency Diploma), is necessary for those young parents, who due to lack of an adequate child care plan, or lack of motivation and other problems cannot attend regular school.

A strong Advisory Council composed of clients and ex-consumers of service provide valuable input into Agency program and design, legislative matters that affect teen-aged parents etc. The Chairman of the Advisory Council as well as other clients are members of the Agency Board of Directors.

In 1977 two new programs were added to LBSC services, ie., a foster care program for teen-aged mother and baby together and a protective service program for teen-aged parents who have come to the attention of Juvenile Court or the Department of Social Services due to neglect or abuse of their infants. Both of these programs are proving successful in the goal attainment of keeping the young family together protecting the infant while the young parent is becoming more capable in the parental role.

The Agency has received praise from both the Wayne County Juvenile Court and DSS for accomplishments in re-uniting these young familes and assisting them to develop skills for independent living. The only criticism has been our limited capacity for case load. We have a long waiting list of referrals each month for the foster homes and had to close intake in the protective service program in March 1978 as it was filled to capacity.

The young fathers are served in all of the programs and services described above and a concrete effort is made by the Agency to reach the young fathers and male partners and involve them in the Agency program.

Funding for LBSC is primarily from United Way (UCS) with the protective service program supported through title XX funds, the foster care program through ADC funds and Wayne County DSS funds. We also have small CETA contracts through the City of Detroit and Wayne County.

Our staff is composed of professional social workers, case-aides, para-professionals, child care workers from professional child development backgrounds working with child-care aids and students, graduate students placed from University of Michigan and Wayne State University, drivers, clerical, administrative staff and administrative assistants.

Lula Belle Stewart Center has been in existence since 1972.

Mr. SHOREY. My name is Clyde E. Shorey, Jr. I am vice president for public affairs of the National Foundation, March of Dimes.

I wish to thank you on behalf of the March of Dimes for the opportunity to testify about S. 2910.

The goal of the March of Dimes is to prevent birth defects and improve the outcome of pregnancy.

Pregnant teenagers are the group at highest risk of having a poor outcome of pregnancy. That is why we have a very major interest in this bill.

The March of Dimes supports the concepts of S. 2910. We believe strongly in the need for a coordinating or linking role to see that the necessary services are brought together and are available to teenagers before and after the onset of pregnancy. This bill should concentrate on that role and the part the Federal Government plays in it.

We do not believe that this bill should seek to fund the major part of the services required to deal with the problems of teenage pregnancy. Such funds should come from established sources—Federal, State, and local. However, funds should be available for seed money or startup costs to get new services under way.

We recommend that the bill provide for the development of educational materials and the training of educators as well as providers of services by organizations with some established expertise.

We recommend that the bill provide for an advisory committee to consult with the Secretary on the issuance of regulations for the program and to participate in an evaluation after several years of operation and for a requirement for maintenance of effort by States and local government.

As I have indicated, our principal concern is the prevention of birth defects, and our primary focus is on delivery of prenatal care and development of educational material.

I would like to point out that in 1975, which is the last year that figures are available on this particular question, there were 280,000 teenage mothers who had late prenatal care or no care at all during pregnancy. This is out of a total of 600,000 deliveries to teenage mothers. Therefore, almost half had no or very little prenatal care.

This points up the importance of the kinds of services that we are talking about to this particular group. Even though the March of Dimes focuses on the health of the newborn, the teenage mother and child need a full range of services such as is contemplated in S. 2910.

The March of Dimes collaborates with other organizations to provide services to teenage mothers. We have funded health education and prenatal care grants to bring together and coordinate services throughout a number of communities throughout the country.

In my statement I have indicated some 14 separate programs where we have done this.

These grants provide essential elements to existing services so they can expand and coordinate various services within the community, to expand the total amount of services that are available to teenage mothers. We believe that the March of Dimes, through these programs, has demonstrated with small seed money grants, that services can be expanded and coordinated in most any community.

We believe that through S. 2910 the Federal Government can accomplish this same objective on a nationwide basis.

We believe that the role of the Federal Government should be to see that the coordination process is initiated in every community. The Federal role need not be involved in working out the detailed plan, but should see that the process gets started. We do not believe that the total responsibility of starting the program should be left to the initiative of others.

I would like to point out that we heard this morning from two States and several cities—and they were picked out to come before this committee because they really had started something—but that is not the case throughout the rest of the country. I think it is important that the Federal role be strengthened and stressed in initiating programs throughout the rest of the country.

As I mentioned, we do not believe that S. 2910 should be considered the principal source for funding of such services as prenatal care or other particular services. We think of this as a coordinating role.

For instance, it seems to us it is much more important that Congress pass the amendment to the medicaid bill, which has been proposed in the President's budget to provide prenatal care to all low-income women. They have established a budget figure of $118 million to cover this amendment. That is the kind of legislation that is going to provide the money for the services that can then be coordinated through the bill that we are talking about today.

In order to pay for startup costs, it is our recommendation that the words "any part of" in section 102(e)—which is the limitation on the amount of funds available that can be used for the payment of services—that those particular words be eliminated. It is our belief that one of the principal purposes of this bill is to provide startup costs which may require the payment of all of those costs as you start the program.

We also believe S. 2910 should put more emphasis on development of teaching materials and guides and sponsorship of training programs for educators and providers. This was stressed by Barbara Blum in her earlier testimony, and Senator Williams has been talking about the necessity of the development of educational material.

The March of Dimes has sponsored and funded a number of such programs. We have done so, together with the Center for the Family of the American Home Economics Association. We have done so together with the National Congress of Parents and Teachers through funding of a program called parenting-PTA priority.

This latter initiative with the PTA has resulted in 17 conferences throughout the country which have been regional in scope. They have included parent leaders, school administrators, teachers, and nurses in the development of curriculum to be used in the schools, and they have been extremely well received. Some metropolitan areas are now starting their own similar conferences to accomplish the same results.

We have also developed new materials to use in connection with the problems of teenage parenting through the funding of a program at Bank Street College of Education in New York City, and with the

Educational Development Center of Cambridge, Mass. These materials have focused on nutrition and prenatal care, on adolescent sexuality and choices about pregnancy, experience of pregnancy and parenthood, responsibilities of parenthood, and birth defects and their impact.

These are brandnew materials. They have just come out within the last few months. They have been well received by the educational community so far and we believe that they, together with the types of programs that we have sponsored with the American Home Economics Association and PTA, are the kinds of educational materials and programs that can be useful and have been demonstrated to be useful in the school system.

We would like to mention that we hope the restrictions of section 102(a)(6), which limits funding of education through consultants, are not so broad that they would restrict the ability to use the expertise of the American Home Economics Association, PTA, Bank Street College, Educational Development Center, or the March of Dimes.

I have already mentioned our recommendation with regard to the Advisory Committee. You have also heard about our recommendation for maintenance of effort by States which is essential if government funds are to be fully effective.

This covers briefly the text of my statement, and I wish to thank you for the opportunity to present it.

[The prepared statement of Mr. Shorey follows:]

Statement By

CLYDE E. SHOREY, JR.
Vice President for Public Affairs
THE NATIONAL FOUNDATION-MARCH OF DIMES

HEARINGS BEFORE THE SENATE COMMITTEE ON HUMAN RESOURCES

On

THE ADOLESCENT HEALTH, SERVICES, AND
PREGNANCY PREVENTION AND CARE ACT OF 1978

July 12, 1978

My name is Clyde E. Shorey, Jr., Vice President for Public Affairs of The National Foundation-March of Dimes. I wish to thank you for the opportunity to testify about S. 2910, the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978.

The goal of the March of Dimes is to prevent birth defects and improve the outcome of pregnancy. To meet this goal we urge that every action be taken to meet the critical health risks to mother and infant that are too often the tragic results of adolescent pregnancy.

The March of Dimes supports the concepts of S. 2910.

1. We believe strongly in the need for a coordinating or linking role to see that the necessary services are brought together and are available to teenagers before and after the onset of pregnancy. This bill should concentrate on that role and the part the federal government plays in it.
2. We do not believe that this Bill should seek to fund the major part of the services required to deal with the problems of teenage pregnancy. Such funds should come from established sources - federal, state and local. However, funds should be available for seed money or start up costs to get new services underway.
3. We recommend that the Bill provide for the development of educational materials and the training of educators as well as providers of services by organizations with some established expertise.

4. We recommend that the Bill provide:

   a. For an advisory committee to consult with the Secretary on the issuance of regulations for the program and to participate in an evaluation after several years of operation.

   b. Requirements for maintenance of effort by states and local government.

You have heard testimony concerning prevention as applied to S. 2910 - that is preventing the pregnancy from occuring. I would ask you to focus for a few moments on one of the principal beneficiaries of this Bill, the unborn and newborn infant. With the focus on the infant, prevention takes on a new meaning and applies to the most important preventive health care in any person's life - prenatal and immediate postnatal care.

Birth defects are the nation's major child health problem. Some quarter-million infants are affected every year by mental or physical handicaps that deny them an equal chance to live full, productive lives. Many of these infants die before their first birthday.

Adolescents bear nearly 600,000 babies each year - one-fifth of the nation's births. Half are illegitimate. The youngest of these teenagers, 17 and under, have the highest rate of any age group of dead or damaged babies.

Low birthweight, our most common birth defect, is prevalent among babies of teenage mothers and substantially greater as a percentage of births than at any other age. Low birthweight is the cause of the greatest number of deaths in the first year of life, and the major cause of disability in childhood. Brain damage

of learning disabilities, often accompanied by emotional and behavioral problems, and structural defects can be a lifetime burden for a baby born too small or too soon.

While prenatal care is not the only influence on birthweight, its importance is obvious wherever data on the outcome of pregnancy have been examined. The results were especially revealing for teenage mothers. A study in New York City showed that among teenagers whose pregnancies were not at either social or medical risk, low weight ratios varied from 5.5 percent for those who began care in the first trimester, to 8.5 percent when care started in the second and third trimesters, to 9.9 percent for mothers who had no prenatal care at all. Among teenage mothers with high risk pregnancies, the low weight ratios also reflected the influence of prenatal care, varying from 15.4 percent of births for those whose medical care began in the first trimester, to 23.1 percent among mothers who had no care at all.

It is primarily the lack of early, continuous prenatal care including adequate nutrition that results in the higher incidence among mothers of this age group of iron-deficiency anemia, hypertension, toxemia, and premature or prolonged labor. In turn, these conditions threaten her baby with greater incidence of mental retardation, physical malformations, and early infant death.

In 1975, some 280,000 teenage mothers in this country either had late prenatal care or had no care at all during pregnancy.

Shame, fear of parental reaction, lack of knowledge of where to get services, lack of funds, or the simple fact that a young girl does not realize she is having a baby, are common reasons

why she does not seek medical help early enough. The relationship between prenatal care and maternal/infant health has been amply demonstrated.

While prenatal health care is only one part of the total services to be brought together by this Bill, it is one of major importance. It must be coordinated with the other services for maximum effect particularly for the newborn infant. Even though the major focus of the March of Dimes is the health of the newborn, we are fully aware that the full range of social, economic and educational services must be brought together for mother and child to assure the newborn any kind of a decent start in life. For this child, a life begun in poverty often continues in poverty and a cruel cycle is perpetuated.

Because of the devastating effects that teenage pregnancy can have on young lives, the March of Dimes has given top priority to the problem of "children having children". Together with national and local leaders in the health, educational and social service fields, we are working to change this dilemma that denies society the potential strengths of these mothers and babies.

Throughout its network of chapters, March of Dimes representatives --staff and volunteers-- collaborate with other organizations in focusing public attention on the concerns of adolescent pregnancy. To stimulate development and expansion of programs fitting community needs, the March of Dimes, as part of this collaboration, has funded health education and prenatal care grants in recent years in an effort to bring together and coordinate services to the high-risk pregnant teenager.

Here are some examples:

A comprehensive teenage obstetrical program at Truman Medical Center, in Kansas City, Missouri;

Salaries and travel assistance for a nurse educator and health educator at the Student-Parent Center for Infants in Ann Arbor, Michigan;

Salary assistance for personnel to conduct a health education program for pregnant students in the School District of Pontiac, Michigan;

Providing salary for a registered nurse to work as health educator with the Young Mothers Program of the San Jose Unified School District in California;

Enabling the Montgomery County Health District, in Dayton, Ohio, to provide maternal health service to adolescents through counseling and teaching. Program emphasis has been on prenatal care, good nutrition, and an understanding of the adolescent's role as a mother in caring for her child's mental, social and physical growth.

Assisting a bilingual health education program for non-pregnant, pregnant, and newly delivered Spanish-speaking teenagers at the Martin Luther King, Jr. General Hospital, in Los Angeles;

Conducting a comprehensive school-age parent education program at Boston Hospital for Women. This is a multidisciplinary, demonstration program in counseling, medical care, day care, and parenting/consumer education;

Defraying salary costs for the Appalachian District Health Department, in Boone, North Carolina, for educational and supportive services in a six-county area;

Salary allocation to Methodist Hospital of Gary, Indiana, for a nurse educator to develop and teach prenatal care courses;

Defraying salary costs of a nurse-educator at Baroness Erlanger Hospital in Chattanooga, Tennessee, serving an obstetrical clinic with many teenage patients;

Providing assistance to the Bradley-Cleveland Community Services Agency in Cleveland, Tennessee, for prenatal care and parenting instruction;

Offering health care, schooling and counseling services at the Margaret Hudson Program for School-Age Parents in Tulsa, Oklahoma;

Providing a grant to Brooklyn Jewish Hospital in New York City for a family health worker at a neighborhood center;

Providing a grant to assist in education for school-age mothers and fathers at the New Futures School in Albuquerque, New Mexico. New Futures provides a broad range of services to adolescent parents throughout the state.

In each instance the March of Dimes grant provided the essential element that made it possible for existing services to expand to cover more of the teenage pregnancy requirements of that community. These grants were made in all types of communities, large and small, urban and rural. The March of Dimes has demonstrated that, with small seed money grants, services can be expanded and coordinated in most any community. We believe that through S. 2910 the federal government can accomplish this same objective on a nationwide basis.

We also believe we have demonstrated that someone must take the initiative to see that this coordination of services gets started in each community. It is essential that local governmental units be brought into the planning and funding of appropriate services. In Columbus, Ohio, the March of Dimes Chapter through a small grant and

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the marshalling of community concern secured the support of the City of Columbus and the Board of Education for a special program for pregnant adolescents at the Bethune Center. The Center provides, or makes referral to, a full range of comprehensive services as proposed in this Bill.

While we will continue to seek to play a similar role in as many communities as possible, we believe that the role of federal government should be to see that the coordination process is initiated in every community. The federal role need not be involved in working out the detailed plan but should see that the process gets started and have the responsibility to monitor progress toward the establishment and implementation of a plan. We do not believe that the total responsibility for starting the program should be left to the initiative of others.

You have already heard testimony urging you not to consider S. 2910 as the principal source for funding of services. This was specifically referred to with regard to family planning services where the major funding comes from Title X of the Public Health Service Act. We believe this should apply to substantially all other services as well. Maternal and child health services, including prenatal and newborn care, are primarily funded from Medicaid, EPSDT, Title V of the Social Security Act and Community Health Centers as well as various state programs. In order to provide the funding for prenatal and immediate postnatal care to teenage mothers it is much more important for Congress to adopt the amendment to Medicaid as proposed in the President's Budget allocating $118 million for prenatal and postnatal care for all low income women. Such an

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amendment to the Medicaid Act is currently being considered in the House of Representatives and should come to the Senate in the near future. It is estimated that of the $118 million, $18 million would apply to services for teenagers. We urge the Senate to pass such an amendment to Medicaid.

The importance of S. 2910 is its coordination function. It should be used primarily for this purpose with sufficient funds available for seed money or start up costs where they are particularly useful in bringing services together to focus on the teenage problem. We believe that sufficient funds should be used to assure the exercise of the federal role to see that the coordination process is carried out in every community. However, in order to be able to pay start up costs for certain new services which may amount to more than 50 percent of those particular services, we urge the deletion of the words "any part of" in Section 102(e).

One element that appears to be overlooked in the Bill is the development of materials for, and the training of, educators as well as providers of services for adolescents. One of the most important roles we believe the March of Dimes has had to play in seeking to have a positive effect on the problem has been the development of teaching materials and guides and the sponsorship of in-service training programs for educators and other providers.

Some examples are:

Collaboration with the Center for the Family of the American Home Economics Association and the funding of teams of university teachers in family life education, nutrition, and child growth and development. These teams worked with schools and colleges in their

regions to upgrade studies in these fields. We also funded a curriculum reader on family life education for grades 5 through 12;

Sponsored in New York City 9 weekly and in metropolitan Chicago 13 weekly in-service training programs for elementary and high school teachers on Parenting Priorities;

Cosponsored with the Junior League and the PTA in Topeka, Kansas and with the Junior League in Boston conferences for providers of services to pregnant teenagers.

Of major importance, and now with national scope, is the joint collaboration between the March of Dimes and The National Congress of Parents and Teachers entitled, "Parenting - PTA Priority". The March of Dimes has funded 17 regional conferences which reached all 50 states and our troops in Europe. The goal of this program is to strengthen family life by upgrading preparenthood education in elementary and secondary schools. Each conference involved teams of parent leaders, school administrators, teachers and school nurses. The subject matter covers many parts of a comprehensive program - maternal and infant health care, nutrition, genetics, family life education, parenting skills and responsibilities, and educational techniques. The success of the regional conferences has now led to a series of metropolitan conferences in many of the major cities.

The March of Dimes has sponsored and funded the development of two sets of special educational materials particularly applicable to teenagers that can be incorporated into the school curriculum. One, prepared by Bank Street College of Education in New York City, focuses on maternal health care and nutrition in pregnancy. The other, prepared by Educational Development Center of Cambridge,

Massachusetts, covers adolescent sexuality and choices about pregnancy, the experience of pregnancy and parenthood, responsibilities of parenthood, and birth defects and their impact on parents and society. While both are brand new they have been received by the educational community with great enthusiasm.

It is especially important to point out that the Educational Development Center materials apply both to the problem of primary prevention of pregnancy as well as to the problems of preventive health care for the teenage mother and her baby. It is our belief that education at the proper time and through appropriate techniques relating to sexuality, pregnancy, and responsibilities of parenthood can have an important impact on reducing the number of pregnancies among teenagers.

We recommend that this Bill, S. 2910 provide for the development of new educational materials, the utilization of existing educational materials such as those developed by the March of Dimes and others and the training of educators as well as service providers in appropriate techniques for dealing with the problems of adolescent pregnancy. The restrictions of Section 102(a)(6) should not be so broad as to prevent the utilization of materials and provision of training to educators and providers by organizations such as the PTA, American Home Economics Association, Bank Street College of Education, Educational Development Center or the March of Dimes.

We wish to support recommendations made by others that the Bill provide for an advisory committee of professionals, and representatives of the teenagers, state and local governmental units and voluntary organizations, who have competence through training and experience to make recommendations to the Secretary on the administration of the

program. These recommendations should specifically be directed to, among others, the issuance of regulations and the evaluation process.

We also support the recommendation for maintenance of effort by state and local governments. This is the only way that Section 103 (a)(5), requiring the program to make use of all other available funds, including state and local funds, can be effective. Maintenance of effort is essential if the federal role is to be primarily one of coordination and seeking to develop new programs from other federal, state and local sources and existing community institutions.

The March of Dimes supports the basic concepts of S. 2910. We believe that passage of such a bill with the recommendations we have suggested may be the best way to launch a nationwide attack on the problems of teenage pregnancy. We urge your support.

I wish to thank the Committee for the opportunity to appear on behalf of the March of Dimes.

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Senator RIEGLE. Thank you, Mr. Shorey. We appreciate your testimony very much.

Dr. Hofmann.

Dr. HOFMANN. Senator Williams and Senator Riegle, I am Adele Hofmann, physician, representing the American Academy of Pediatrics, an organization of nearly 20,000 pediatricians dedicated to improving the health and welfare of all our growing young from infancy through adolescence.

In recent years the Academy has expanded its concern for our growing young to include adolescents, and we feel it is an important and expanding role for pediatricians to have influence in this area, perhaps from a somewhat different perspective than has been testified to before today.

My other credentials include being associate professor of pediatrics at the New York University School of Medicine and director of the Adolescent Medical Unit at New York University Medical Center-Bellevue Hospital, and I am also the immediate past president of the Society for Adolescent Medicine, which shares in the views that I present today.

I shall not review my written testimony in its entirety. You have it before you.

I would like to stress certain points from the perspective of the pediatrician and adolescent medicine specialist; perspectives which are somewhat different from those of persons who have primary concerns with the issue of human sexuality and pregnancy as secondarily applied to adolescents. My point of departure is that of broad concern for all aspects of the health and well-being of teenagers of which pregnancy is but one piece, albeit a most important one.

S. 2910 has singular importance in that it supports a concept which has been noted by some of my predecessors this morning, that of a wholistic approach to the human being. I think that regardless of how much funds are involved, and no matter how small a piece of the pie is ultimately going to get funded, these fundamental precepts and concepts should not be lost in the context of exactly how much money gets spent. What a bill says and the way it is said in terms of philosophy and approach can be as important in establishing principles as what it actually supports economically.

There are elements of this bill which are relatively exciting to those of us in adolescent health care. It stresses comprehensive health care and pregnancy within this context. Pregnancy is but an intercurrent event in the total life of the adolescent, albeit an event with significant and serious consequences. We hope this perspective will not be lost. We therefore urge that a developmental context be preserved and that the problem not be viewed solely categorically, external to the continuum of a young person's growth as he or she emerges from childhood dependency and seeks his or her own independence and individuation in the process of becoming an autonomous adult.

It is an easy matter to view teenagers in alternating and polarized fashion as either children or young adults; as either dependent family members or emancipated youth. In fact, they are neither and the developmental approach views adolescents as members of the family unit, and separate from it, in the process of individuation and self-

actualization, at one and the same time. This fundamental concept has to be incorporated in any kind of health system approach, or multiservice approach; the concept that teenagers have one foot in the home and one foot in the outside world at one and the same time.

A health care model for adolescents, whether for pregnancy or anything else, is one which seeks to help young people assume responsibility for their own life, but in a guided and supported fashion, rather than imposing arbitrary decisions made solely by adults, leaving decisional matters wholly up to the adolescent. We urge that any legislation relative to the health needs of this age group assume this developmental and longitudinal perspective as a fundamental base.

A second point is that successful health services to adolescents requires an interdisciplinary approach, rendered by professionals who are trained and experienced in working with this age group, understand their biological and psychological needs, and are skilled in building a supportive and trusting relationship. The training of teachers in adolescent development for instance, is greatly neglected, as it often is for service providers in family planning programs. Regrettably, health services and sex education are frequently rendered by those who do not have the requisite training, compromising the likelihood of programmatic success. We urge that training provisions and standards of professional competency as specifically relates to adolescents be included in the provisions of this bill.

My third point is that any decision in resolving an unwanted pregnancy is what one must call "a least worse" decision. There is no good solution to it. It is a bad solution whatever way you turn. Any answer has its elements of tragedy. Certainly avoidance of pregnancy in the first place is a far more desirable goal. In this we vigorously support the statements of earlier testifiers as to the importance of sex education. There simply has to be, through whatever mechanisms, more openness in the provision of responsible, relevant sex education. In this instance, I am going to put the burden of responsibility for having failed to incept an age-oriented approach not on young people, but on the professionals who are providing services. What is needed is an approach which helps young people to explore their own options in daily behavior and make their own decisions in a guided manner. How rare, today, is the chance for girls and boys to talk together under guided leadership about what to do in the dating situation, how to handle instinctive drives and new sexual feelings. How do you say, "no" if you want to say, "no"? Is it OK to say, "yes"? How does the boy or girl feel about premarital sex? What is "sex appeal"? What is "macho"? What values are important for each individual within the context of their own family upbringing? These are questions young people rarely have the opportunity to honestly explore and find answers to, and hence, act out of impulse or ignorance. These issues must be brought out into the open and discussed with young people as well as specifics on contraception and reproductive plumbing. Too often only the latter matter is covered in what is euphemistically called sex education in most schools.

By extension, this position also requires nonjudgmental support for the young boy or girl who takes either course, to be sexually active or not. In the former instance, contraceptive services must be made

available whenever and wherever the girl can best enter the health care system—and the boy, I would add. There are many ways in which young people enter health care systems, not just family planning clinics. This includes comprehensive hospital-based adolescent clinics, neighborhood health centers, school health programs, working paper physical examination clinics, health screening in boys and girls clubs and the like. There is an expanding interest in broad, comprehensive, adolescent health services in medical clinic settings, not just specifically family planning programs. We need to involve all of these resources. Young people obtain health care in many places; 7 percent of all teenagers see a physician at some point during a year.

Fourth point is that once a girl becomes pregnant we urge that all options will be made available to her. The Academy is committed to the proposition that all children should be born well and born wanted. We affirm the right of the adolescent to determine her own fertility fate and consider the penalty of being forced to bear an unwanted child high indeed. She alone is not responsible for her fate and is part victim to a system propagated by we adults which dismally fails in educating her for responsible sexuality in contemporary society and dismally fails to provide a rational system of available contraception. So we urge that this bill include all options for adolescent pregnancy resolution including termination as well as bearing a child.

Fifth, a major problem with past health care legislation has been its categorical problematic-oriented nature. Try to get funding to put together a care package that responds to the total needs of the person and you find yourself turning first to this agency, then that one and then another, often unable to even identify who has what funding resources. It is exceedingly difficult to put together a comprehensive program. Also, eligibility requirements often are highly restrictive, based on factors beyond the quality of care given or the population served.

Thus while we affirm and applaud this bill, which at least conceptually addresses the comprehensive approach, we view it as inadequately integrated with other existing and related programs. We specifically urge that this bill be linked up and integrated with the provisions of Title X and Title V legislation. A great deal also could be done in cost containment and avoidance of duplication through such a linkage. Coalescing the immediate concerns of S. 2910 with those of family planning and child and maternal health will go a long way toward providing such an approach.

My sixth point refers to the specifics where funds should be applied. It is our contention that much can be done through the expansion of and building on existing services.

One can take existing health services, add certain amount of moneys to hire two or three key people and build on a very good program that expands the capacity of that facility to deal with sexuality.

Last, I would like to touch on something that I have not heard a word about today and happens to be a particular concern of mine, and that is that no barriers be introduced in enabling adolescents to gain access to contraceptive and pregnancy-related services. We would view the introduction of parental consent and/or notification requirements and the failure to incorporate provisions protecting a minor's

health record privacy in light of new privacy protections as such a barrier. Many young people simply will not involve their parents until too late, either becoming pregnant in the first place or deleteriously delaying prenatal care, if their parents must know as a condition of obtaining treatment.

We at the Academy are ardent supporters of family integrity and of the perspective that, in principle, teenagers are indeed best advantaged by having parental guidance and support. It is certainly our goal as professionals to encourage this direction and we share with parents the desire to insure the well growing up of their child.

But we are also pragmatists and recognize that good communication between parent and youth is not always possible, and that in some families, those where communication is least likely to occur, parents and their young are at such odds as to make adult guidance and support from within the family unlikely.

We as health providers must be free to provide protection from unwanted pregnancy, guidance and support unfettered by mandatory requirements for parental notification and consent. We urge that the legislature, parents, and the public have some trust in well-trained adolescent health professionals and understand that they too seek the best for the young and not impose such mandatory requirements.

Mr. Chairman, Senator Riegle, I thank you again for this opportunity and also ask that you consider all the further points in our written testimony as well.

Thank you.

[The prepared statement of Dr. Hofmann and additional material supplied for the record follow:]

AMERICAN ACADEMY OF PEDIATRICS

Testimony before the

Human Resources Committee

Adolescent Health, Services, and Pregnancy
Prevention and Care Act of 1978
S. 2910

Presented by

Adele D. Hofmann, M.D.
July 12, 1978

Mr. Chairman, I am Adele D. Hofmann, M.D., representing the American Academy of Pediatrics, an international association of pediatricians dedicated to improving the health and welfare of infants, children and adolescents. I am a member of the Academy of Pediatrics' Committee on Adolescence, a board-certified pediatrician, Associate Professor of Pediatrics at New York University School of Medicine and Director of the Adolescent Medical Unit at Bellevue Hospital.

I am pleased to be here to discuss with you and members of the Committee the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978, introduced by Senator Kennedy on behalf of the Administration. Let me first say that the Academy's commitment to adolescents and their health is both profound and long-standing. We believe that the pediatrician is often in the best position not only to introduce infants to quality health care but to retain them in the health care system through their childhood and adolescent years. The trust, confidence and rapport established between patient and physician during that span have obvious beneficial consequences to our country's youth.

Mr. Chairman, I do not consider it necessary to deluge you with facts and figures documenting what is now so often described as an epidemic of adolescent pregnancy. Our presence here today acknowledges the magnitude of the problem; we must now solve it. I am confident no one here will dispute the drastically higher mortality rates for infants born to young, adolescent mothers (less than 16 years of age), who in most cases discontinue their schooling upon becoming pregnant and often suffer irreversible emotional harm, many times joining the welfare ranks. It is indeed disturbing that our health, educational and social service systems have failed to address these adverse consequences of adolescent pregnancy in a satisfactory and comprehensive manner. Federal programs have in the past been unfocused and ill-suited, and this fragmentation of effort has resulted in a system fraught with gaps and inefficiency. With this history in mind, the Academy of Pediatrics applauds the intent of the legislation we are considering today, as well as the Administration's initiative in the area of adolescent pregnancy, as a tentative step in the right direction. It is imperative that services, programs and benefits be better coordinated.

The Academy, while supporting the intent and framework of this bill, views it as somewhat idealistic. The bill does address the significant weakness of existing services to adolescents, i.e., the lack of coordination and linkages between primary services and specialized secondary levels of care for the many medical, psychological, social and developmental problems of the age group. But a systems analysis of newly designed programs must occur in order to achieve an integrated network of services rather than isolated programs unattached to either primary or secondary sources of care, as the case may be. It is also our firm belief that this bill's success hinges on delivery of services by persons specially trained in adolescent care, whether it be medical, nutritional or counseling in sexual or vocational education. Demonstrated competence in adolescent care by those delivering services under the bill's provisions is the key--and I cannot overemphasize the importance of the word "demonstrated." In order to insure that services delivered under the Act's provisions be by specially trained and qualified persons, we would suggest a specific clause be included in the Act directing that federal implementing guidelines require adequate levels of training in adolescent care for those delivering services.

At the same time, we are faced with a critical shortage of just the type of person needed to deliver adolescent care and services. We would urge that the bill's provision for training providers of multidisciplinary services be recognized for what it is--the primary determinant of the bill's chances for successfully addressing the needs of adolescents.

Unfortunately, teen-age pregnancy is characterized by late entry into the prenatal care system. This is especially disturbing since early maternal care is associated with a more favorable outcome for both mother and infant. A critical survey of adverse health consequences of teen-age pregnancy reveals two major complications: preeclampsia-toxemia and an excessive number of low-birth-weight babies. All other potential ill effects of teen-age pregnancy appear to be dependent not on adolescence itself but upon the socio-economic class of the teenager and whether the pregnant teenager has access to a health system.

Low-birth-weight rates from teen-age pregnancy reportedly range from 6 per cent to 20 per cent. Irrespective of socioeconomic class, data from different centers using the gynecological age or the time interval since menarche, rather than chronological age, as a basis of comparison, confirm a higher rate of low-birth-weight infants among young teenagers. Some investigators have found a higher incidence of low birth weight associated with a gynecological age of two years or less.

The higher incidence of low-birth-weight infants and the unfavorable outcome of that phenomenon appear to be the major childbearing hazards facing the pregnant adolescent. Other risk factors associated with teen-age childbearing--socio-economic class, cigarette smoking, alcohol and drug use and improper nutrition--are not age-related but affect all pregnancies. It therefore appears that the biology of adolescence

contributes only minimally to the health-associated risks of teen-age childbearing. Different data sources do, however, suggest an association between adolescent childbearing and behavioral or physical problems in infants born to young adolescents:

- Children born to adolescent mothers have a notably higher incidence of childhood mortality, apparently in association with a higher rate of childhood accidents.
- One Canadian study concluded that adolescent mothers were more likely to have handicapped children.
- Another study reported that 11 per cent of children born to girls less than 16 years of age scored less than 70 on I.Q. tests at age 4 compared to 2.6 per cent for the general population.
- This same study noted that school failure and behavioral problems were also more prevalent in children born to young adolescents.
- Other reports link increased child abuse and neglect, delinquent behavior and early pregnancies to the population born to young teens.

The pregnant adolescent is also subject to several unfavorable psychosocial hazards. She is usually economically dependent, is forced to interrupt her schooling and has not had sufficient time to complete the developmental tasks of adolescence. The father of her baby often deserts her, and considering the anger engendered in the family by an unexpected pregnancy in a young unmarried daughter, it is apparent that these girls bear an awesome social burden. The postponement of teen-age childbearing would result in improvement in almost all these adverse reactions in both the adolescent mother and her baby.

Some teen-age mothers will encounter little difficulty in their pregnancies, and their children will develop normally. Nonetheless, the younger the mother, the greater the risk of health-associated consequences of pregnancy, low birth weight and subsequent abnormal child development. Delaying the first pregnancy until the late teen-age years or early 20's substantially diminishes these risks.

Hence, for the young adolescent it is apparent that the burden of pregnancy and implications of having a baby, wanted or unwanted, can result in tremendous liabilities for both her and her child. Regardless of whether the fetus is carried to term or the pregnancy is terminated, comprehensive programs and services must be easily accessible and directed to adolescents if they are to become an integral part of and a contributor to society.

Before addressing possible solutions to the "crisis" situation surrounding pregnant adolescents, we must project ourselves to the desired outcome of programs designed to meet the needs of this population. While reducing infant mortality and salvaging pregnancy are noteworthy goals, as pediatricians we are more interested in the quality of the

lives that are preserved--quality for both mother and child. We certainly do not expect all young, pregnant adolescents to elect to remain in the school system or to demonstrate a reduced frequency of low-birth-weight infants. Nor can we presume to identify what constitutes a satisfactory outcome of a young teen-age pregnancy. However, we strongly believe that constructive programs will contribute significantly to the societal adjustment of the adolescent and her child and to the overall quality of their lives. We can do no less for this growing, at-risk population.

Mr. Chairman, the Academy believes this bill's emphasis on linkage of adolescent health care services rather than on the problem of adolescent pregnancy itself is both appropriate and long overdue. The bill's very title recognizes the importance of this approach. For too long we have been concerned with the problem itself instead of its causes and effects. Adolescent pregnancy will not disappear as a social problem next year or in the foreseeable future, so it is appropriate that we direct ourselves to the total spectrum of health care and social adjustment of this segment of our population.

In this regard, the Academy would specifically commend several of the bill's provisions:

- Addressing primary pregnancy prevention in young adolescents, whether it be for initial or repeat pregnancies.

- Linking sexual, parenting and vocational education with other services offered. We would caution, however, that to be effective, those educational programs must be tailored to meet the special needs of adolescents and directed toward understanding sexuality and fostering responsible sexual behavior.

- Stressing coordination of federal policies and programs providing services related to prevention of initial and repeat adolescent pregnancies. We would recommend special emphasis be given to coordination of Title X of the Public Health Service Act and Title V of the Social Security Act, thereby facilitating monitoring of referral and follow-up services and improving continuity of care. Services for maternal and child health under Title V would seem to be an especially appropriate target for this bill's intent to link its services with those already in place.

- Providing training to providers of adolescent services under the Act. As pointed out earlier, this is a key area. Only those with demonstrated competence in the area of adolescent health services should provide those services. Otherwise, the success of the entire program could be jeopardized.

We do, of course, have other concerns which we feel merit attention if this adolescent pregnancy initiative is to be successful. It would be appropriate and constructive to include in Section 102(6)(b) among the types of services to be linked under the program, "adoption and foster care counseling and day-care services." Without these additions, which

were recommended in the Joseph P. Kennedy, Jr., Foundation's "Essential Components in a Comprehensive Adolescent Pregnancy Center," the spectrum of care offered is incomplete.

We also consider it necessary that counseling and supportive services be available for adolescents choosing to carry their baby to term as well as for those choosing to terminate their pregnancy. The Academy's philosophy is that all children should be wanted and born to healthy mothers. If unwanted pregnancy occurs, or if there is evidence of abnormality or genetic defect of the fetus, consultation should be obtained. Alternatives should include acceptance of parental responsibility for the child, adoption or termination of pregnancy. Furthermore, low income should not deprive an individual of any of these alternatives.

The Academy would also suggest that the Act encourage but not require parental consent for services. A model act for consent of minors for health services is attached as Appendix A.

Mr. Chairman, I consider it particularly appropriate that when this bill was introduced in the Senate, confidentiality of medical records was identified as a topic that this bill should certainly address. We agree wholeheartedly. The Academy considers several points essential for any future confidentiality of medical records legislation: medical records should be a collaborative effort between patient and physician, the patient should own his medical record, physicians should be permitted to maintain fully privileged working notes, medical record release should be negotiated between the patient and third parties, confidences of parents and minors should be separately maintained and periodic review and expungement of medical records should be required. Should the Committee elect to incorporate confidentiality provisions in this bill and require more detailed analysis of the issue, we stand ready to provide that analysis.

In conclusion, Mr. Chairman, I feel that I must speak out against the bill's limited scope. I am aware of the fiscal restraints under which you must work, yet I fear for those geographic areas which have no services in place to link to services provided under this Act. Are we going to deny these areas new services simply because of present deficiencies? Are we going to compound an existing problem with eligibility requirements that many areas of our country will find difficult to meet? At the same time, Mr. Chairman, the Academy of Pediatrics finds much to be commended in the bill despite its limits of scope. We subscribe to the philosophy that linkage of pre-natal, intra-partum and post-natal services is the only appropriate way to address the problem of serving our adolescent population. With these linkages should come greater interdisciplinary collaboration (e.g., among pediatricians and obstetricians-gynecologists) and a more unified approach to the delivery of services.

APPENDIX A

AMERICAN ACADEMY OF PEDIATRICS

COMMITTEE ON YOUTH

A MODEL ACT PROVIDING FOR CONSENT OF MINORS FOR HEALTH SERVICES

PREFATORY NOTE*

This Model Act is drafted with the purpose of stimulating all states of the union to review their statutes in regard to minors' consent for health services. It intends to be all inclusive to give the individual state the option to adopt part or all of this Act whenever it sees fit.

In a democratic nation such as ours, individuals' rights are paramount. In order for everyone, including minors, to have the right of obtaining health services, the balance of this right against others becomes of the utmost importance. This Model Act accepts the concept that getting health services is a basic right. Also, it accepts that parents have their basic right of protecting and promoting the health and welfare of their minors. Therefore, this Act is a compromise and a balance of these two basic rights in the conditions specified. The goal of this Act is to insure that all minors can have quality health services by granting the minors self-consent in conditions and instances that will prevent them from seeking services if parental consent is required and by encouraging health professionals to deliver quality services to minors without incurring legal liability. Reasonable safeguards and limitations are stipulated in this Act to protect the minors' safety and the right of the parent. This Act also emphasizes the promotion of family harmony and minor's maturity.

Whereas, certain minors are not obtaining adequate medical, dental, or other health care due to current legal and medical obstacles.

Whereas, providers of medical, dental, and other health care are now vulnerable to legal action for giving care to minors,

Whereas, there is a need for coordination, stimulation, and support of access to medical, dental, and other health care for certain minors in need of such care without violating the rights of parents to protect and promote their minors' health,

Be It Enacted by the Legislature of the State of ———, as follows:

Section 1. For the purposes of this act:

(1) "Minor" means any person under the age of majority as defined by the State statute or under 18 years of age, whichever is lower;

(2) "Health Professional" means state licensed physician, psychologist, dentist, osteopathic physician, nurse, and other licensed health practitioner;

(3) "Health Services" means health services specified by the state, appropriately delivered by different health professionals including examination, preventive and curative treatment, operation, hospilization (admission or discharge), giving or receiving blood and blood derivatives, receiving organ transplantation, pledging donation of organs after death, the use of anesthetics, and receiving contraceptive advice and devices;

(4) The masculine shall include the feminine.

Section 2. Any person who reaches the age of majority or 18 years of age or is on active duty with or has served in any branch of the Armed Forces of the United States shall be considered an adult in so far as the consent for health services is concerned.

* This Model Act has been approved by the Council on Child Health of the Academy. It is recommended for enactment in all the states.

Section 3. Notwithstanding any other provision of law, the following minors may give consent to health professionals for health services:

(1) Any minor who is or was ever married; or has had a child, or graduated from high school, or is emancipated; or

(2) Any minor who has been separated from his parent, parents, or legal guardian for whatever reason and is supporting himself by whatever means; or

(3) Any minor who professes or is found to be pregnant, or afflicted with any reportable communicable disease including venereal disease, or drug and substance abuse including alcohol and nicotine. This self-consent only applies to the prevention, diagnosis, and treatment of those conditions specified in this subsection. The self-consent in the case of pregnancy, venereal disease, and drug and substance abuse also obliges the health professional, if he accepts the responsibility as the provider of the health service, to counsel the minor by himself or by referral to another health professional for counselling.

The health professional may, but shall not be obliged to inform the parent, parents, or legal guardian of the minor of any treatment given or needed when:

(a) in the judgment of the health professional severe complications are present or anticipated; or

(b) major surgery or prolonged hospitalization is needed, or

(c) failure to inform the parent, parents, or legal guardian would seriously jeopardize the safety and health of the minor patient, younger siblings, or the public; or

(d) to inform them would benefit the minor's physical and mental health and family harmony.

Such information shall be given to the minor's parent, parents, or legal guardian only when the minor consents or when because of the minor's age or condition the attending health professional can reasonably presume such consent.

Notification or disclosure to the spouse, parent, parents, or legal guardian by the health professional shall not constitute libel or slander, a violation of the right of privacy, a violation of the rule of privileged communication or any other legal basis of liability. When the minor is found not to be pregnant, or not afflicted with venereal disease, or not suffering from a drug or substance abuse, including alcohol and nicotine, then no information with respect to any appointment, examination, test, or other health procedure shall be given to the parent, parents, or legal guardian, if they have not been already informed as permitted in this Act, without the consent of the minor.

(4) Any minor who has physical or emotional problems and is capable of making rational decisions, and whose relationship with his parents or legal guardian is in such a state that by informing them the minor will fail to seek initial or future help. After the professional establishes his rapport with the minor, then he may inform the parent, parents, or legal guardian unless such action will jeopardize the life of the patient or the favorable result of the treatment; or

(5) Any minor who needs emergency care, including transfusions, without which his health will be jeopardized. The parent, parents, or legal guardian shall be informed as soon as practical except in conditions mentioned in subsections 1, 2, 3, or 4 of this section; or

(6) Any minor who has had a child may give effective consent to health service for his child; or

(7) Any minor may give consent for health care for his spouse if his spouse is unable to give consent by reason of physical or mental incapacity.

Section 4. No consent of anyone else including parent, parents, custodian, legal guardian, or any court shall be required for any person mentioned in Section 3 except where specified. Consent of the minor shall not be subject to later disaffirmance or revocation because of minority. The spouse, parent, parents, or legal guardian shall not be liable for payment for such service unless the spouse, parent, parents, or legal

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guardian have expressly agreed to pay for such care. The minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services except those who are proven unable to pay and who receive the services in public institutions.

Section 5. If major surgery, general anesthesia, or a life-threatening procedure has to be undertaken on a minor with his consent, it shall be necessary for the physician to obtain approval from another physician for the management except in an emergency in a community where it is impossible for the surgeon to contact any other physician within a reasonable time for the purpose of concurrence.

Section 6. Self-consent of minors shall not apply to sterilization or abortion.

Section 7. No consent shall be required of any minor who does not possess the mental capacity or who has a physical disability which renders him incapable of giving his consent and who has no known relatives or legal guardians if two physicians agree on the health service to be given.

Section 8. Except by specific legal requirement, no information in regard to venereal disease, drug and substance abuse, pregnancy, and emotional illness shall be given by the health professional to another professional, school, law enforcement official, court authority, government agent, spouse, future spouse, employer, or any other person without the consent of the minor, unless giving the information is necessary to the health of the minor and the public and only when the minor's iodentity is kept confidential.

Section 9. The consent of the minor who represents that he may give effective consent under this Act for the purpose of receiving health services but who may not in fact do so, shall be deemed effective for the purposes of prevention, diagnosis, and treatment required without the consent of the minor's parent, parents, or legal guardian if the person rendering the service relied in good faith upon the representation of the minor.

Section 10. Any health professional may render or attempt to render emergency service or first aid, medical, surgical, dental, or psychiatric treatment without compensation to any injured person or any person regardless of age who is in need of immediate health care when, in good faith, the professional believes that the giving of aid is the only alternative to probable death or serious physical or mental damage. For major surgery or any dangerous procedures concurrence of another physician shall, if practical, be obtained.

Section 11. Any health professional may render nonemergency services to minors for conditions which will endanger the health or life of the minor if services would be delayed by obtaining consent from spouse, parent, parents, or legal guardian.

Section 12. Any minor who is examined, treated, hospitalized, or receives health services under this Act may give legal consent, and no person who administers such health services shall be liable civilly or criminally for assault, battery, or assault and battery, or any other legal charge, except for negligence or intentional harm, for treating such minor without advising his parent, parents, or legal guardian.

Section 13. In the event of emergency, either parent or legal guardian may authorize by writing or by telephonic communication with a witness any adult to give consent for a minor who himself is unable to give self-consent for health care for whatever reason.

Section 14. Nothing in this Act shall require any health professional to provide service, nor shall any health professional be liable for such refusal.

Section 15. The Governor shall appoint an Advisory Committee that shall have the responsibility of promoting and encouraging the availability of health services for minors; shall conduct and develop resources of payment, private or public, for the rendering of such services; and shall recommend regulations to carry out the conditions and purposes of this Act.

Section 16. In the event any section, sentence, clause, or provision of this Act shall

be declared invalid by any court of competent jurisdiction, such action shall not affect the validity of the remaining sections, sentences, clauses, or provisions of this Act which shall continue effective.

Section 17. This Act shall become effective immediately upon passage and approval of the Governor.

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ADELE D. HOFMANN

ADOLESCENTS, SEX, AND EDUCATION

Because many of the unmarried young have determined that sexual activity is as valid an alternative as chastity, sex education should encourage students to make reasoned choices and to behave responsibly in their own framework.

The estimate that 11 million teenagers are sexually active in the United States today (1) seriously challenges us to ask ourselves if non-marital intercourse is invariably detrimental for our young. Too frequently we have cloaked this issue with denial, avoidance, and our own anxieties. We seem to be engaged in a conspiracy of silence, deluding ourselves with the illusion that unless a teenager is pregnant or has venereal disease, sexual intercourse among adolescents simply does not occur. Or we believe that if sexual intimacy is talked about openly, heretofore unthought-of ideas will be put into the heads of adolescents and their instinctive drives actuated.

Nor have we been able to define effectively the relative rights and responsibilities of parents, of educators, and of the youths themselves in relation to sex education. Primarily concerned with conveying intellectual facts and with attempting to mold teenage sexual behavior to relatively conservative adult standards, we have not often taken into account the modifying factors of adolescent development itself in either psychological or historical terms. Failure to respond to these issues results in an inevitable failure to educate the young constructively about sex.

The basic truth is that each generation of adolescents must be assisted to seek and define its own identity, moral code, and behavior if it is to meet effectively the demands of a rapidly changing world. If youths are to accomplish these goals, they cannot be expected simply to incorporate static traditions.

My intent in this paper is to examine various shifts in adolescent coital behavior and to explore corresponding shifts in the nature of parental authority, minors' rights, and sexual morality, relating the latter to its derivations in ancient taboo. For an analysis of these factors inevitably suggests to me that the greater sexual freedom that obtains today is a mark of social advance. At the very least, we are inescapably drawn to the conclusion that many of the unmarried young have determined for themselves that sexual activity is just as valid an alternative as chastity, regardless of adult views. In responding to these observations, I shall propose that an understanding of the foregoing matters, together with knowledge of adolescent psychological development, offers a sound basis upon which to formulate a more satisfactory educational plan.

If we accept that these contemporary changes lead also to the conclusion that a sexual morality for the young cannot be dictated, although it may be implicit in their upbringing, we must accept too that adolescents may be benefited most by encouragement to devise an individual value system derived from the past but flexible enough to meet the future. It is unlikely that they will be helped by present methods of sex education, which provide only part of the truth and little opportunity for students to test out their own views, explore options, make reasoned choices, and behave responsibly out of their own inner motivations.

Indications that sex education has not been effective rest in such facts as these: in 1974 more than 1 million teenagers, aged 15 to 19 years, became pregnant; 600,000 babies were born out-of wedlock; 270,000 abortions were performed; and there were 100,000 forced early marriages. Among those under 15 years of age, 30,000 more became pregnant. (2) Only one out of every five states mandates sex education in any form; and only one-third of all high schools teach about birth control. Young people themselves report that the vast preponderance of conveyed information revolves simply around the biological facts of reproduction and puberty, and few believe that their behavior was significantly influenced by what they were taught. (3)

Adolescent Sexual Behavior

The only data we have on sexual activity in the United States in the past came from Kinsey in the 1940s, who found that by the age of 17 years some 10 percent of all females in his study had premarital sex. (4) By the age of 20 this figure was nearly double. Coital experience was not significantly influenced by the girl's final educational level, as was true for boys, but she was far more likely to have had intercourse as a single woman if she ultimately became married than if she did not. This represented a tenfold increase in the proportion of sexually active single teenaged females over the previous thirty years. Indeed, some 40 percent of all married females in Kinsey's time had premarital intercourse, usually during their engagement. For the most part, regardless of age, coitus was with but a single partner for whom the girl cared deeply and with whom she anticipated a permanent alliance.

Only one out of every five states mandates sex education, and young people report that the conveyed information deals primarily with biological facts. Few adolescents believe their behavior is significantly influenced by what they were taught.

Nearly three decades later, in 1970, Kantner and Zelnick carried out a national sampling of 4,000 adolescent girls, 15 through 19 years old, and found that 27 percent of those who were white admitted to having had coitus by the age of 17. (5) By the 19th year 46 percent were sexually experienced. This represents more than a doubling of the earlier Kinsey rate. Their behavior, however, can hardly be called promiscuous in the epidemiological sense any more than it was some twenty-five years ago. The majority of girls continued to have relations with a single partner whom they loved and hoped to marry. This trend is further supported by the more limited studies of Luckey and Nass and Christensen and Gregg in interviewing college students, and in the smaller à-la-Kinsey sampling of Hunt. (6)

Admittedly, results obtained from highly personal and intimate questionnaires are inevitably distorted to some degree by answer bias. It is also difficult to compare statistical information obtained in one study with that from another when there is significant disparity in survey designs and populations (e.g., Kinsey's study contained no minority groups).

Turning to males, Kinsey found in the 1940s that 61 percent of adolescent boys had sexual intercourse by the age of 17, and 72 percent by age 20. (7) For the most part young males obtained their experience with prostitutes, unless they were in the year prior to marriage. In more contemporary times, Luckey and Nass and Hunt found that there has been an increase in the already high incidence of coitus among adolescent males, particularly among the college-bound. They are also now much more likely to have relations with their dating partner than with a prostitute. (6) Finkel and Finkel recently surveyed 421 boys between 12 and 17 years of age residing in a large northeastern city in the United States. They found 69 percent admitted to being sexually experienced, and more than three-fourths had their first coital experience before their 16th year. (8)

Additional evidence of change comes from Vener and Stewart who surveyed a high school population of nearly 1,000 males and 1,000 females between 13 and 17 years of age in both 1970 and 1973. These adolescents lived in a white, middle-class, non-metropolitan, midwestern community of 25,000 inhabitants representative of "Middle America." Here, too, there was a definite rise in the incidence of sexual activity among teenagers over even this three-year span. In 1970, 27 percent of male and 16 percent of female students affirmed that they were experienced. In 1973, this rose to 33 percent and 22 percent, respectively, with a particularly pronounced rise among 14- to 16-year-olds and a suggestive trend for both sexes toward coitus more often with multiple partners. (9) This is the first intimation of a possible shift in the essentially monogamous pattern characteristic of teenage females.

Further confirmation comes again from Zelnick and Kantner. Surveying a second national probability sample in 1976, they found that 8 percent more teenage girls were sexually experienced and 10 percent more had multiple partners than in 1971. (10) It can now be estimated that of our nation's 21 million 15- to 19-year-olds, over 4 million girls and 7 million boys are sexually experienced. Even one-fifth of all 13- and 14-year-olds have had sexual intercourse at least once. (11)

We must conclude that young women in the United States are indeed more sexually active at an earlier age than in the

past. Young white males seem to be doing just about what they always did, but now with a dating partner rather than with a prostitute. They also tend to be sexually active at an earlier age. We have insufficient information to make similar comparisons relative to minority groups; current data, however, demonstrate that young black females are twice as likely to be sexually active as white females. (5)

If the changing patterns of sexual activity of the past fifty years continue on their present course, we will soon arrive at a time when the preponderance of American teenagers, girls as well as boys, will have engaged in coitus prior to their 20th year. There is little to suggest a different outcome, or that we could reverse this trend. Further, this is not a reaction to any new or recent events—neither the counterculture movement of the sixties, nor the availability of "the pill" and other contraceptive devices—for few girls anticipate initiating coital behavior with any advance pregnancy protection plan, and a significant number fail to use effective birth control methods on any consistent basis. (10) Rather, the change is far more deeply rooted in the past.

Children in America

The first New England colonists, whose views on child rearing had considerable influence on subsequent directions in education, saw the young as firmly possessed of original sin to be atoned for in a lifelong search for salvation. The way was marked by hard work, absolute obedience to parents and masters, diligence in learning, attending church, and the observance of premarital chastity. Life for children was supposed to be strict and disciplinarian. The family was central in these matters, and schools were but secondary. (12)

Colonial economic success and the climate surrounding the Revolution combined to modify these early child-rearing attitudes along more realistic and pragmatic lines. In a new age of volunteerism and self-help youths were expected to achieve righteousness through their own decisions and actions rather than through the vigilance of others. This trend was further reinforced by the influence of neighboring mid-Atlantic and southern colonies which had been founded more on commercial grounds than on religious principle. (13)

Despite continued requirements of absolute obedience to parent and master, a new principle emerged: each generation not only could be something more than the last, but it bore this charge as an obligation. Any child could, and indeed should, grow up to be "better" and more successful than his predecessors, a concept that has been labeled the American Dream. This futuristic orientation toward the young led to a much more flexible and open attitude toward child rearing, which in turn allowed adolescents a greater opportunity for personal freedom, experimentation, and the assumption of new roles.

In another direction, the mid-1800s found significant numbers of immigrant children laboring long hours in mills, mines, and factories. A cadre of child advocates arose outside of the home, championing the welfare rights of the young. The last quarter of the nineteenth and the early twentieth century were marked by widespread enactments of a variety of protective laws ensuring that children received what the state held to be proper nurturance and were not subject to harm. (14) The earlier disciplinarian attitude toward children had given way to one of benevolence. The young were to be saved from harmful external influences rather than from their own excesses and improvidence. This protection became just as much the responsibility of the state as it was of the family.

Compulsory education laws gave schools a far greater role in child rearing than was true heretofore. But as far as inculcating moral values was concerned, schools were not in an enviable position. How does one rear children and adolescents to hold onto past values while at the same time selectively and individually rejecting those that impede the finding of a new and better way? The dilemma is succinctly stated by Eli Ginzberg, the economist:

> A society dedicated to change must be willing to assume a critical attitude toward many of its own basic experiences and must further be willing to restrict its own authority in favor of newer, radical ideas. Only to the extent that young people are brought up differently from their parents can a society seriously hope to fashion a world that is better. (15)

From a psychoanalytic perspective, "growing up differently" also poses a significant threat to the autonomy and validity of those adults currently in charge. The maturation of the young inevitably heralds the ultimate retirement and, hence, downfall of the old. This dilemma is considerably greater in our society than in one in which there is no rejection of the past and parental views are recapitulated and perpetuated in their offspring. In consequence, American youths frequently encounter unconscious hostility toward that which they represent and a negation of any change in values from the past. Sexual behavior is, in our culture, often at the forefront here, both as an issue in and of itself and as a symbol of all intergenerational change. It becomes an arena for the contest over control between young and adult.

Roots of Premarital Chastity

While not casting a shadow on religious principles *per se*—it is important to recognize that moral values do not emerge in an emotional or social vacuum. They are deliberately, albeit unconsciously, constructed to defend against inner psychological conflict and anxiety or against threats to a culture's

Support for the magical concept of women as dangerous within patriarchal societies is found in the story of Adam and Eve; in myths like Odysseus and Circe; and in witch-hunts such as the one which culminated in the sixteenth-century public hanging pictured here.

social and economic order. While Western civilization has come from a moral base which proscribes sexual freedom among its unmarried young, this is not and never has been a universal requirement in all cultures (as is true of curbs placed on aggressive drives), nor one which is imposed upon both sexes in equal measure.

Reich and Nemedik collectively offer convincing evidence that premarital chastity requirements are not only primarily visited upon girls, but on girls within a patriarchal system. (16) One cannot help but conclude that the asset of female virginity is strongly tied, first, to tribal economics wherein an "unused" daughter brought the better bride-price, and wherein children born out of wedlock had no inheritance rights if inheritance moved through the paternal line; and, second, to primitive magical thinking wherein there was inherent danger in menstrual and hymenal blood, just as the blood that flowed from wounds was obviously associated with weakness and sometimes with death. Add in primitive man's animistic beliefs holding that evil spirits lurked everywhere, including body orifices, ready to do harm if not properly propitiated or exorcised. It becomes relatively easy to contemplate how primitive patriarchal societies saw the female as both "safe," as far as evil spirits were concerned, and of economic worth, only if she were kept premaritally virginal and if defloration and menstruation were surrounded by protective rites and rituals.

Support for this magical concept of women as dangerous within patriarchal societies is found in the biblical story of Adam and Eve; in such myths as Perseus and Medusa or Odysseus and Circe; in the prohibition against intercourse during menses and the ritual post-menstrual bathing practices in orthodox Judaism; in the Salem witch trials; and, in more modern times, in the singular absence of empathy often encountered by women who have been raped, because they are perceived as seducers.

Quite a different view obtains in those cultures which are more matriarchal in structure. Margaret Mead's Samoan adolescents and Malinowsky's Trobriand youngsters, for example, enjoyed wide latitude in premarital sexual encounters. Indeed, sexual freedom among teenagers was the norm with the exception of a few selected girls who were, by their birth, destined for marriage within the highest chief circles. (17)

The contrast between matriarchal and patriarchal societies in the degree of permissible sexual behavior among the young has particular application today. The history of the women's liberation movement, both suffragette and contemporary, and the move toward a more sexually egalitarian society have also been accompanied by increasing sexual activity among the female young. Girls are now coming to participate in sexual behaviors which have long been, at least covertly, permitted to males. The real implications of increasing sexual freedom, then, are political and cultural in a gradual shifting away from absolute paternalism. It is not simply testimony to the licentiousness of the young, the breakdown of the family, or the abdication of parental responsibility deriving from the "permissive" environment of the youth movement in the 1960s.

Minors' Rights and the Law

The colonial climate of absolute parental authority and the erosion of this position in the nineteenth and twentieth centuries through the widespread enactment of protective laws have already been noted. In this manner the state and its agents came to be invested with far greater responsibility for the child than heretofore. But the young were still subject to adult determination and did not have rights of their own in a constitutional sense.

A wholly new direction was introduced in 1967 when the United States Supreme Court ruled that minors indeed were entitled to much, but not all, of the Bill of Rights in juvenile court procedures. (18) This trend moved into education in

The women's liberation movement and the change to a more sexually egalitarian society have been accompanied by increased sexual activity among young females. Girls are now participating in sexual behaviors that have long been permitted to males.

1969 with *Tinker v. Des Moines Independent School District* establishing a student's right to freedom of speech, and it expanded in subsequent decisions in such matters as the right to due process in suspension hearings and freedom of religion in relation to compulsory education. (19).

This confirmation of minors' rights has also moved firmly into the realm of privacy in health care and into sexual matters in particular. (20) All states now have laws specifically permitting minors to consent to venereal disease treatment on their own. Many also have similar provisions relative to pregnancy and birth control.

Some states have more broadly incorporated a "mature minor doctrine," holding that persons of sufficient maturity or intelligence to understand the nature of the risks and benefits of proposed treatments, regardless of their nature, are entitled to give their own consent. Others approach definitions of emancipation for health-care matters through more specific definitions, employing such criteria as age (anywhere from 14 to 18 years) or life-style status (being married, a parent, in the armed forces, or employed and self-supporting). A few states address this issue in even more general terms, stating that a minor need only be away from home and managing his or her own financial affairs in order to give a valid consent. Considerable statutory diversity exists from one locale to another, and only general trends can be given here.

But the law is more than stotutory regulations alone. While it has been widely held that only a parent could contract for a minor's care, and that treatment in the absence of parental consent could constitute assault and battery, courts have not always taken this interpretation. A growing body of case law supports the right of self-consent for minors who are mature enough to understand a treatment's risks and benefits. No decision has yet been uncovered in which damages were awarded against a physician who treated a minor over age 15 for any matter or provided an adolescent of any age with pregnancy-related services.

In 1976, the United States Supreme Court addressed the issue of parental consent requirements for the first time. In the first of two significant decisions, it firmly supported minors' rights to equal protection by holding that states may not require a minor to have parental consent in order to

obtain contraceptive services from those federally subsidized programs whose funding guidelines prohibit discrimination based on age or marital status. (21) In the second, striking down a Missouri law which, in part, required parental consent for a minor's first trimester abortion, the Court said:

> The State may not impose a blanket provision requiring the consent of a parent or person *in loco parentis* as a condition for abortion of an unmarried minor during the first twelve weeks of her pregnancy. . . . The State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy. . . . Minors, as well as adults, are protected by the Constitution and possess constitutional rights. (22)

While far from clarifying all matters relative to permissible regulations governing a minor's access to health care, or his rights to privacy, these decisions are indeed significant. They lead to the conclusion that the Court views the parent as but a temporary ombudsman and advocate during that period when the child is incapable of acting rationally and knowledgeably on his own behalf. With increasing maturity, the child, now youth, becomes endowed by both law and psychological fact with the capacity to make his own best decisions in a graduating manner. The current trend draws the lines of emancipation and self-determination developmentally rather than by arbitrary age factors. The parent is no longer the absolute owner of the child, and the child is no longer inflexibly subject to the will of parent or state.

This change should pose no threat to those families that provide a milieu of emotional health. They have, in many respects, always provided their young with exactly the type of graduating responsibility that the law now stipulates. It is also true that a healthy, nurturing relationship between parent and child will always take psychological precedence over outside social and legal force. This new body of law has its greatest impact in ensuring that minors will be seen as individuals in and of themselves under less advantageous circumstances.

Psychological Perspective

The extent of sexual freedom among adolescents in our culture is not the issue in debate. It is, rather, that we take a carefully considered approach derived from understanding, and not one that stems from taboo and unconscious conflict.

In a developmental perspective, contemporary Western adolescence is considerably more expanded in both time and scope than it is in simpler cultures, and we cannot entirely equate one with the other. The extended educational requirements of a technologically demanding economy and the complexities of growing up in an open-ended, future-orientated, pluralistic society make the processes of separation and individuation difficult to negotiate. To give adolescents full license for sexual exploration at all developmental stages can well add burdens they are not yet ready to take on. It is important to key sex education to stages of physical and social maturation.

Erickson has defined two tasks of adolescence: first, emancipation from parental ties; second, the finalization of a separate identity in intellectual, moral, functional, and sexual terms. (23) It is sexual identity that we are particularly concerned with here. Early adolescents are heavily invested in the normalcy of their biological development. At the peak of pubertal growth, young teenagers are singularly preoccupied with the progress of statural and reproductive maturation. They initially seek confirmation of their maleness or femaleness in comparison with members of the same sex and determine their capacity for being accepted and liked among same-sex peers. This period ends when the adolescent achieves a sense of security, worth, and self-esteem among those of his or her own gender.

No less narcissistic than at the early stage, the mid-adolescent moves on to try out these same matters with opposites and dating partners. Once assured of competence in this regard, and possessing a secure and comfortable sense of self, the youth finally becomes capable of entering into a mutually caring, sharing, and responsible relationship with another for the first time. Gone is the narcissistic investment of earlier years. The waiving of all restraints upon physical intimacy can place a heavy extra load on negotiating early developmental steps but will be less so or even not at all toward the end.

Adolescence also provides time for coming to grips with those conflicts that inevitably exist between instinctive drives and that behavior which is deemed acceptable and necessary by a given society for the maintenance of order and continuity. Resolution of the obvious dichotomy between sexual fantasies and activated drives, through masturbation or intercourse on the one hand, or the abstinence dictated by social expectations on the other hand, remains a major issue for young people today. Nor can we ignore the implications of psychoanalytic theory. Oedipal conflicts resurface at adolescence, and separation from parental ties and the capacity to establish a family of one's own require that this, too, be worked through.

New interpersonal relationships can be difficult to establish in an open-ended society, and they have variable import depending on the adolescent's particular stage. Early and mid-adolescent relationships normally take place within a narcissistic frame, and sexual intercourse at this time inherently has an exploitative quality bearing a potential for emotional harm to one or both partners. No less is experimentation a normal part of these years, trying on new and different behaviors to see which ones work best in the search

for a valid identity. Unable to see clearly the consequences of actions taken on new and uncharted ground, and often but weakly guided by adults who find themselves shackled by an inability to talk openly about sex, teenagers are all too often left to explore and experiment sexually all on their own. They may well miscalculate the consequences out of ignorance.

Implications for Sex Education

How, then, can we mount a constructive approach toward adolescent sexuality? There is no contest with the view that any culture requires a set of moral values within which to operate for its own integrity and continuity. Both parents and outside educational forces have firm obligations to this end. But the American social system incorporates significant possibilities for evolution and change. We must also be open to this fact.

The failure to appreciate adolescent development within a contemporary context, and the singular difficulties posed by attempting to reach a consensus in a pluralistic, changing environment, inevitably result in conveying mixed and confused messages to the young about what they should or should not do. The error is in trying to find a single set of acceptable sex behaviors for all adolescents at all times and then trying to bring this about through external coercion.

We must first ask what are we trying to achieve? Are we seeking simply to avoid adverse consequences, such as preventing teenage pregnancies through the conveyance of contraceptive knowledge? Do we seek to limit our impact on venereal disease to the transmission of data on prevention and treatment alone, without really looking at the underlying cause? Or are our goals to help young people deal more responsibly with their sexuality in broader terms, and what does being "responsible" mean?

Even if returning young people to the practice of non-marital sexual continence were a desirable goal, the analysis of trends in adolescent sexual behavior belies its feasibility. We must also question the extent that traditional education can actually modify the sexual practices of the young at all. Irwin has postulated that personal experiences within a developmental context have a far greater impact on modifying adolescent health behavior than externally imposed dictums or facts. (24) Although adults generally respond to intellectually perceived benefits in health matters, teenagers seem to test, refine, and incorporate new health perceptions, primarily through a sequence of developmental steps and direct life experiences. We as parents and educators have not yet recognized this signal difference in the matter of sex behavior, nor have we provided young people with a forum for open dialogue utilizing this concept as the base.

Sex education classes are all too frequently led by persons who are not trained in adolescent development, or who have themselves not examined their own feelings about sex and those ways in which this is reflected in their teaching. Health educators are not immune to "hang-ups" and ignorance. Nor are parents able to talk easily about intimate issues with

Unable to see the consequences of their actions, and often but weakly guided by adults, teenagers are left to explore and experiment sexually on their own. Out of ignorance they may miscalculate the result

emancipated offspring. The young are essentially left to their own devices and the questioning of peers to find their way.

Instead, adolescents need an unbiased, open educational forum wherein they can freely explore their own concepts and come to their own conclusions within the context of that particular morality in which each was individually raised. This looks at such matters as alternatives, consequences, and responsibilities in various possible sex behaviors, from free sexual activity to total continence. Elimination of secrecy, hidden taboo, and uncountered peer pressures, together with the opportunity to understand human sexuality within a comprehensive frame encompassing anthropological, social, developmental, psychoanalytic, and biological principles will provide a proper educational milieu. On the agenda for such forums might be discussions of the meaning of intimacy, contraception, homosexuality, masturbation, programmed male aggressiveness, the double standard in male-female morality, sexual guilt and exploitation, dating and interpersonal relationships, or, even, how to say "no."

The next step in this model is the provision of support for, and acceptance of, the youth's own particular best decision. This cannot be accomplished without a sense of mutual trust: trust on the part of the educator that adolescents are far more capable of rational and responsible sex behavior than they are generally credited with; and trust on the part of young people that adult motivations rest in helping them grow up in the best way they can and not in an indoctrination with an arbitrary set of values, or in an intergenerational struggle for control, or simply because espousing a rigid sex morality is the safest and least provocative course. Without mutual trust little can be accomplished, for the young will neither bring their true thoughts to the surface nor heed guidance; impulsivity will continue to reign.

Last, while one might well wish on a developmental basis that young people would decide not to engage in sex until they had at least arrived at the mutually caring stage, or on moral grounds that they would not at all, it is necessary to realize that even those who have intellectually elected abstinence will not necessarily always follow this course. The non-judgmental acceptance of an adolescent's behavior is essential. As already noted, teenagers are by nature experimenting, and this developmental proclivity is further enhanced by our cultural valuation of that which is new. Blame should not be heaped upon those who transgress. Rather the goal is to help them work out feelings, issues, and the path ahead without imposing additional guilt or blocking the resolution of conflict. Probably the most fatal pitfall in working with adolescents is to succumb to a confrontational power struggle between youth and adult. This is akin to waving a red flag at a bull and is a contest no one can win.

At the core of all that has been presented here is the conviction that the young are not the possessions of parents, or of society; they are the possessors of their own selves. Adults are but temporary guardians until the young become sufficiently mature to make their own best decision over the circumstances at hand, even if this is in conflict with the past. It is our obligation to provide a flexible, supportive environment in which this can be accomplished. It is only in this way that youth will be able to meet successfully the challenge of social evolution and change.

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Adolescent Pregnancy in the United States

A Review of Causes, Risks and Some Suggested Solutions

by

Adele D. Hofmann, M.D.
Director, Adolescent Medical Unit
Department of Pediatrics
New York University Medical Center
Bellevue Hospital Center
New York, New York

In 1974 the World Health Organization defined adolescence as the period during which:

1. The individual progresses from the point of the initial appearance of the secondary sex characteristics to that of sexual maturity;

2. The individual's psychological processes and patterns of identification develop from those of a child to those of an adult;

3. A transition is made from the state of total socioeconomic dependence to one of relative independence.[1]

It is within this context that pregnancy in the teen years must be examined. The adolescent period is one which comprises a specific and unique time in the life cycle; a time of rapid growth and development. The biological and psychological events are definable, consistent and predictable. Yet a specific age cannot be rigidly assigned. Even though puberty progresses through a particular sequence of events, genetic, environmental and nutritional factors all contribute to broad variation in the range of normal; plus or minus two standard deviations in the age of menarche; for example, may encompass a span of four years.

Further, the cultural milieus in which adolescence takes place are myriad in their variety and significantly affect the time of onset, duration and manifestations of psychosocial development. It is essential that we understand such modifications by examining the goals of each family in terms of the particular life purpose it seeks for its children and its child rearing techniques in achieving those ends. In primitive families and societies, the prime aim of child rearing often is the addition of another member to insure continuity and enhance the probabilities of survival of the family unit as a whole;

the child becomes another potential child bearer, a food gatherer, a hunter, a warrior on a system where safety rests in numbers and extended family units in defense against the hostility of nature and other tribes. At the opposite pole are middle class families in the United States where a major goal of child rearing is the achievement of autonomy and the capacity of the child to ultimately leave home and stand independently on his or her own two feet. [2]

Pregnancy in adolescence, then, occurs within the context of a biological, psychological and social continuum. It can not be removed out of this context; it can not be approached in a cultural and biological vacuum. Considerations must begin far in advance of conception and extend far beyond the end of the gravid state. Too often the causes of adolescent pregnancy, issues of primary prevention, and long term consequences upon both the adolescent partners and their child are given scant attention, with the preponderance of concern being confined to the few months of gestation.

We also must examine the broader demographic consequences of early childbearing. Initiation of a family during the teen years extends the period of fertility for each generation involved, with a far greater cumulative fertility and rapid population growth than will occur when pregnancy is deferred. While this paper will not examine population demography per se, we must always keep in mind the urgent issue of population control for all nations, and for underdeveloped areas in particular whose gross national product is insufficient to support this growth. Singular dilemmas are posed to the economic futures of nations having the preponderance of its citizens under the age of 25 consequent to a lowering of infant mortality without a concomitant decrease in the birth rate.

Our considerations of pregnancy in adolescence introduces yet a third pervasive theme. Conception in the teen-age years frequently occurs outside the confines of marriage.

Deeply rooted moral and religious values supporting sexual abstinence among the unmarried strongly color our ability to examine this issue with a clear and unbiased mind. In some subcultures adolescent sexual experience has always occured with some frequency, but open consideration has been taboo. In other instances, recent social change has been accompanied by an increasingly greater sexual freedom among the young. This has been viewed variably as a mark of deterioration of the family with a loss of both virtue and parental control; or as simply a manifestation of shifting values appropriate to the times.

Coitus and pregnancy are not diseases in and of themselves to be eradicated in toto as is true for malaria, smallpox and typhoid fever; rather it is the context in which these events take place. The dilemma (and point of intergenerational conflict) rests in defining just what this context shall be. The young and their elders may well differ markedly in their respective views. It is difficult indeed to explore these matters dispassionately. Yet so we must if we are to truly understand and arrive at effective solutions. This is not to imply that the moral perspective should be abandoned by any means, but rather that it not blind us or block rational consideration.

Causes of Adolescent Pregnancy:

The essential biological fact of pregnancy is that coitus must have occured between a fertile male and fertile female without contraception. In examining causality in adolescents, then, we must look, first, at fertility; second, at coital behavior, and, third, at contraceptive practices. Further, in relation to behavioral aspects, we must explore both rational (conscious) and irrational (unconscious) factors.

Fertility: Cutright [3] has recently pointed out that some 40% of the increase in in incidence of adolescent pregnancy which occured between 1940 and 1960 in the United States could be accounted for both by a lowering in the age of menarche and a decrease in

spontaneous fetal wastage. Over the past 75 years, the mean age at which a girl initiates menses has dropped from 14 1/2 years to 12 1/2 years. Attributable to improved nutrition (and possible genetic factors as well) Frische and McArthur [4] have advanced the theory than menses are triggered by the arrival of an optimal body weight, estimated in their studies to be approximately 47 kg. While subsequent investigations have not fully substantiated this theory and place greater emphasis on a critical level of hormonal factors such as the brief nocturnal lentinizing hormone surges which make their appearance several years before menarche and gradually increase in magnitude and duration, [5] it does remain an attractive thesis that some aspect of lean body mass or total body water in some way contributes to the initiation of puberty and subsequent events.

While it now appears that the menarcheal age is stabilizing at the current age of 12 1/2 years and little further drop is predicted, it is incontestable that a two year reduction in arrival of ovulation in combination with better nutrition and better health care have collectively enhanced the probability that adolescent sexual activity will result in pregnancy. Add to this an expanding adolescent population in absolute numbers and the increased rate of coitus in this age group and the magnitude of the dilemma of teen-age pregnancy looms large indeed.

Coital Behavior

Examination of the work of Kinsey in the 1940's and early 1950's found that about 20% of all females had sexual intercourse prior to their 20th year and this usually with their intended marital partner. [6] Among males, Kinsey found 80% of non-college-bound males and 40% of those going on to higher education were sexually experienced, most often with a prostitute. [7]

In a 1976 survey of 15-19 year old females, Kantner and Zelnick [8] found that somewhat more than half of all 19 year olds have had coitus at least once. This was a significant increase even over a similar national sampling these investigators carried out five years earlier. [9]

Table 1: Percent of never-married women in the United States aged 15-19 who have ever had intercourse by age and race, 1976 and 1971.[8]

	Study Year and Race					
	1976			1971		
Age	All	White	Black	All	White	Black
15-19	34.9	30.8	62.7	26.8	21.4	51.2
15	18.0	13.8	38.4	13.8	10.9	30.5
16	26.4	22.6	52.6	21.2	16.9	46.2
17	40.9	36.1	68.4	26.6	21.8	58.8
18	45.2	43.6	74.1	36.8	32.3	62.7
19	65.2	48.9	83.6	46.8	39.4	76.2

It is particularly noteworthy that the patterns of behavior among black adolescents are substantially different than that for whites, suggesting some very real cultural differences between these two groups. Comparable data is not available from Kinsey as these studies included no minority groups.

In the 1971 survey Kantner and Zelnick found a monogamous pattern similar to that of Kinsey's time. But in 1976 there was greater evidence for multiple partners, a trend first intimated by Vener and Stewart [10] in their sampling of teenagers in a "conservative" mid-west United States community.

Table 2: Percent of sexually experienced never-married women in the United States aged 15-19, by number of partners ever, 1976 and 1971.[8]

	Number Partners			
Year	1	2-3	4-5	6 or more
1976	51	32	8	9
1971	63	26	6	5

Considerably less information is available for United States males. Finkle and Finkle [11] enquired as to the practices of 421 New York City boys, age 12 to 17 years, and found 69% admitted to being sexually experienced with more than three-fourths having their first coital episode before their 16th year (in contrast to girls whose mean age of initiating sexual intercourse was at, rather than prior to age 16, according to Zelnick and Kantner).

In summary, then, there is sufficient evidence to conclude that adolescent males in the United States have beensexually active to a high degree for three decades at least, with the predominant change being in a lowering of the age of initiation of such behavior among all boys and an increase in the rate of coitus among those bound for higher education, approximating that formerly found among those with a secondary school education alone. The preponderance of change has occured among adolescent females who appear to be gradually assuming patterns similar to those long engaged in by the opposite sex. The issue never seems to have been male virginity, but rather that of females in a covert double standard of acceptable behavior. One might conjecture that the increase in coital behavior by adolescent girls simply reflects a social shift toward sexual equality rather than moral decline.

Contraceptive Practices: Certainly the use of effective birth control has been a major factor in reducing the number of pregnancies world wide. But not so for the adolescent. Many investigators have pointed to the low rate of contraceptive use among teen-agers in the United States. Again referring to Zelnick and Kantner [8] as the most recent and comprehensive investigators, while improved usage has occured over the past five years, 70% of 15-19 year old sexually active girls still fail to use some form of birth control regularly or fail to use it at all. And among those who do use a method all

the time this is not necessarily one which is notably reliable.

Table 3: Percent of sexually experienced never-married women in the United States aged 15-19 according to contraceptive use status by age, 1976 and 1971.[8]

	Use Status							
	Never		Sometimes		Always		Last Time	
Age	1976	1971	1976	1971	1976	1971	1976	1971
15-19	25.6	17.0	44.5	64.6	30.0	18.1	63.5	45.4
15	38.0	32.9	32.5	47.4	29.5	19.7	53.8	29.9
16	30.9	20.6	38.7	58.9	30.5	20.5	56.3	38.8
17	29.4	12.2	41.4	70.8	29.3	17.0	61.8	45.2
18	20.8	13.0	49.1	70.1	30.1	16.9	70.2	48.8
19	21.1	14.6	54.4	68.4	30.5	19.0	68.8	55.3

Table 4: Percent distribution of sexually experienced never-married women in the United States aged 15-19 according to method of birth control used at last intercourse by age, 1976 & 1971.[8]

	Age					
	15-19		15-17		18-19	
Method	1976	1971	1976	1971	1976	1971
Pill	31.2	15.1	21.6	7.7	42.9	23.0
IUD	2.2	0.8	1.3	0.2	3.4	1.4
Condom	12.6	14.4	15.2	17.3	9.3	11.2
Douche	2.3	1.7	2.4	2.1	2.3	1.3
Withdrawal	10.6	10.3	14.9	9.4	5.4	11.3
Other	4.5	2.9	3.9	2.4	6.3	3.4
None	36.6	54.8	41.6	60.9	30.4	48.4

One must regrettably note a decline in the use of the condom for all ages and an increase in the use of withdrawal by the very young. Further, there is as yet undocumented evidence that the recent disclosures over the long term risks of the "pill" in terms of

cardiovascular disease appear to be scaring away adolescents from this form as well, even though the risk appears to be primarily among older women rather than the adolescent young.

In exploring the reasons for contraceptive non-usage, teenagers cited three major reasons; they considered themselves to be too young to become pregnant; they believed it was "the wrong time of the month" - with many erroneously perceiving precisely when the "safe period" was; and/or they did not know where or how to obtain a method and perceived major barriers in visiting a doctor for this purpose. Smaller percentages did not wish to use any method because of aesthetic or medical reasons; and a few did not mind becoming pregnant or actually wanted a child.[9] Clearly, from the teen-ager's conscious perceptions, the preponderance of unprotected intercourse took place out of either ignorance of reproductive facts or difficulties in obtaining an effective method of birth control. Many teen-agers are unlikely to seek out family planning services if parents have to consent or otherwise know, if institutional and proceedural barriers exist, if they must pay beyond a most modest fee, and/or if the services are only obtainable in a disapproving and guilt provoking environment.

Perhaps more important are unconscious factors. It is a fact that even among adolescents who have already been pregnant and who are in a highly supportive and age-oriented health care program which emphasises responsible sexuality and contraception, compliance is notoriously poor. In a six year follow-up of adolescent mothers in one such a program at Yale University, a pioneer in the development of comprehensive programs for pregnant teens, 40% resorted to either abortion or sterilization for fertility control.[12]

In terms of development, the teen-ager is characterized by an intense need to explore the world and experiment with new feelings, thoughts and deeds in their search for identity and independence. They tend to be more oriented to the moment and their feelings than to long range consequences and intellectual appraisal of responsibilities. While this impulsivity need not be compelling and overriding, it tends to be so in matters which are little discussed in the open and in which no genuine guidance in exploring options and their implications is provided; this is particularly true about sex. Further, young people tend to unconsciously protect themselves against the anxiety raised by the obvious consequences of normative exploratory, risk taking behavior (also characteristic of these years) by massive infusions of denial and magical thinking that they are somehow immune from dire effects.

Secondly, adolescents are intensely grappling with issues of control; control over self and others as they emerge from their former dependent state. Adolescent emancipation drives frequently manifest themselves in power-struggles and contests over just who is in charge. When sexual issues are dealt with by an arbitrary adult "no", the challenge to rebell against such dictums can be seductive indeed.

In many instances one also finds coital behavior by teens to unconsciously respond to a broad variety of emotional distress. Thus intercourse in and of itself can provide a degree of intimacy and "proof" of love to an otherwise emotionally deprived youngster who has difficulty in establishing warm and rewarding interpersonal relationships in any other terms. It may also convey a sense of being "grown-up" to one who feels unfairly forced to remain a dependent child.

Pregnancy also has its special meanings. Both boys and girls are given clear proof of their masculinity or femininity through their ability to procreate. This can be

an important unconscious motive if they are particularly insecure in this regard. Bearing a child can be perceived as bestowing instant adulthood on a girl who is dissatisfied with her adolescent life. So, too, can this provide someone to love and be loved by in a total and absolute sense; an important motivation in a teen-ager who feels unwanted, rejected and alone. Other unconscious determinants that have been identified in some pregnant girls are rivalry with the girl's mother or older sister; punishment of oneself for partaking of forbidden behavior or even for forbidden thoughts; punishment of parents; as surrogate to the teen-ager's own mother's wish to bear another child in the maintenance of her identity as a child rearer, now threatened as her fertile years draw to a close and her own children grow up.

Certainly, not all of these factors are at work in each pregnant girl, and others certainly exist as well. It is also true that many instances of pregnancy result simply out of accident, out of institutional and other externally imposed barriers in obtaining birth control or to factors in the cultural milieu which tacitly condone early sexual experimentation, even if frowned upon in a public sense.

This brief consideration, however, does not necessarily add clarity to our understanding or direction to our course. Rather it points up the singular complexity of adolescent pregnancy and the requirements for far greater research into the issues of adolescent psychological development and health care compliance; for the perception that this is a very different issue for teen-agers than for adults; and for the need for carefully devised programs taking all such matters into consideration to be effective at all.

Adolescent pregnancy; frequency and outcomes in the United States:

It is estimated that approximately one million teenagers in the United States become pregnant each year with the following outcomes in 1974; [13] (Table 5)

	Age	
	15 years or less	15-19 years
Postmaritally conceived	0%	27.6%
Premaritally conceived, postmaritally born	6.4%	10.0%
Out-of-wedlock births	35.4%	20.6%
Abortions	45.2%	27.4%
Spontaneous miscarriages	13.0%	14.4%

One third of all legal abortions now performed in the United States occur among women under 20 years of age. [14]

Fertility in the United States generally declined between 1961 and 1974, presumably due to the combined impact of improved contraceptive technology and the legitimization of abortions. While older teen-agers have shared in this decline to some degree, younger ones have not and the rate of births to this age group have increased. [13]

Table 6: Approximate number of births per 1,000 U.S. females by age. [13]

	20-24 yrs.	18-19 yrs.	14-17 yrs.
1961	260	155	31
1965	200	130	28
1970	160	110	30
1974		88	29

However, the situation becomes more dramatic when marital births are excluded and only infants born out-of-wedlock are considered. In this set of circumstances, births to older women declined by about 25%; but those to females aged 18-19 years increased by one

third; and those to 14-17 year olds nearly doubled.[13] Clearly neither contraception nor abortion were widely practiced by teens during these years.

Table 7: Approximate number of out of wedlock births per 1,000 unmarried U.S. females by age.[13]

	20-24 years	18-19 yrs.	14-17 yrs.
1961	40	25	8.5
1965	39	29	10
1970	39	32	13.5
1974	29.5	33	16

In comparing the number of total births per 1,000 females aged 15-19 with those of other countries, the United States ranks higher than many European countries, but lower than in Latin America.

Table 7: Number births per 1,000 females age 15-19 years in Selected Countries; 1970[13]

Japan	5	France	29	Israel	41
USSR	18	Belgium	30	Italy	43
Netherlands	17	W. Germany	31	Australia	54
Spain	17	Sweden	31	Hungary	57
Switzerland	19	Portugal	33	U.S.A.	58
Ireland	20	Canada	36	Romania	61
Denmark	28	Greece	39	New Zealand	63
				E. Germany	72

Table 8: Percent out-of-wedlock births to all women and percent of total live births (marital and non-marital) to women under 20 years of age; 1963-69.[1]

Country	% total births that were out-of-wedlock	% all live births to women under 20 yrs.
U.S.A.	10	17
Chile	15	
Mexico	18	11
Columbia	20	
Costa Rica	21	15
Peru	30	
Venezuela	30	15
Dominican Rep.	60	10
Barbados	65	24
Guatemala	65	17
Panama	65	

Another international comparison is offered by the Population Reference Bureau in a 1976 report.

Table 9: International comparisons of childbearing and marriage among teenage women; selected data for women under 20 years of age; 1969-1973.[15]

	Birth rate	% all births	% of all illegitimate births	% all marriages
U.S.A.	68	19	25	33
England/Wales	50	11	21	26
Sweden	33	7	60	7
Japan	5	1	5	3
France	26	7	17	20
Chile	70	15	30	31

Risks of Adolescent Pregnancy:

Risks attendant to pregnancy in the teen-age years must be examined from three different perspectives; biological, social and psychological. Each will be examined in turn.

Biological risks: Pregnant teenagers have long been viewed as a particularly high risk group. The data does support higher rates of prematurity, toxemia, anemia, and both maternal and infant deaths for this age group.[13] However, there is no greater incidence of congenital anomalies than exists among those in their optimal childbearing years; the observed higher rates of mental retardation, cerebral palsy, learning disabilities and epilepsy are directly attributable to the increased rate of prematurity and, possibly, to the higher incidence of prolonged and precipitate labor for which these neurological deficits are all corollary. Further, while it has been stated that there is a greater incidence of cephalopelvic disproportion, no supporting data exists indicating a higher rate

of Cesarean section among the very young, and as noted labor is just as apt to be precipitate as it is prolonged. Grant and Heald [16] analysed selected existing data thus;

Table 10: Comparison of certain complications of pregnancy between adolescents and non-adolescents.[16]

	Mothers ≥ 20 yrs.	Mothers ≤ 19 yrs.	Significance
Fetal death	1.7%	1.5%	$0.3<p<0.5$
Neonatal death	2.0	2.4	$0.05<p<0.1$
Perinatal death	2.6	2.7	$p>0.5$
Prematurity	9.6	14.2	$p<0.001$
Toxemia	2.2	6.0	$p<0.001$

These authors conclude that prematurity and toxemia are the major biological risks for pregnant teens, but that the outcome was greatly influenced by age (with younger adolescents significantly more at risk than older ones) and by socio-economic status and race (poor black teenagers were at greater risk than non-poor white girls).

Prematurity: The increased number of infants weighing less than 2500 grams is probably the major biological consequence of teen-age pregnancy. This fact has been well documented by many investigators such as Chase. [17]

Table 11: Percent of low birth weight infants by age of mother and color; United States; 1950 and 1967. [17]

	Total		White		Non-white	
Age	1950	1967	1950	1967	1950	1967
<15	15.1	17.2	15.9	12.2	14.7	19.5
15–19	9.0	10.5	8.0	8.5	12.0	15.7
20–24	7.3	7.7	6.9	6.7	9.8	13.2
40–44	7.7	9.6	7.5	8.3	8.9	12.2

This data gives additonal confirmation to the conclusions of Grant and Heald; and further documents the observation that the younger the girl, the less evident are factors of race and income status; and that the incidence of prematurity rises for all groups as maternal age diminishes. The over-all rise in incidence of prematurity between 1950 and 1967 is attributable to decreased fetal wastage consequent to improved health care resulting in a higher percent of pregnancies ending in a live birth, even if premature, than in miscarriages or still born infants.

A more recent analysis, carried out in 1973, determined a prematurity rate of 13% for those under 15 years; 9% for 15-19 year olds; 6% for persons aged 20-39; and 9% for those 40 years or more. [18]

Infant mortality rate; Here, too, age and socioeconomic status contribute significantly.

Table 12; Infant mortality of white and non-white infants by age of mother; United States, 1970 [19].

Age	Rate per 1,000 live births	
	White	Non-white
<15	48	65
15-19	28	49
20-24	21	40
40-44	27	45

Particularly noteworthy is the very great increase in infant mortality which becomes evident with increasing birth order. While adolescents have a lower infant mortality rate than do those over 35 years of age in so far as their first child is concerned, with subsequent offspring the chances of the infant dying during the first year of age soars and dominates all other groups. While a significant proportion of these deaths are predictably, consequent

to prematurity, other causes of mortality enter in as well including higher incidences of infections and trauma.

Table 13: Infant mortality rates per 1000 live births by maternal age and birth order, selected areas and years; 1967-72.[20]

Birth Order	Age Under 20	20-24	25-29	30-34	35-39	40-44
First	127	92	94	116	144	185
Second	196	115	88	94	102	142
Third	262	144	101	94	108	126
Fourth	241	156	105	90	100	121

Maternal mortality: Maternal mortality rates in the United States have undergone rapid declines over the last 30 years. In 1940 the rate was 376 per 100,000 live births; in 1966 it was 25. Adolescents have shared in these events and in countries whose over-all mortality rate is less than 40 per 100,000, adolescent mothers do not constitute a group singularly at risk of death. However, in underdeveloped areas where the over-all maternal mortality rate is greater than 216, teenagers do seem to be somewhat more vulnerable than persons between 20 and 30 years of age, but still less so than those over 35.[20] Thus maternal mortality is not selectively a greater health risk for teenaged mothers than for older females in her community.

Table 14: Maternal mortality; Rate per 100,000 live births by maternal age for selected areas and years (1962-66)[20]

Area	Average rate	Age in Years 20	20-24	25-29	30-34	35-39	40-44
Low mortality level	26	33	31	39	77	162	248
Moderate " "	55	39	39	47	81	156	230
High " "	158	62	42	55	89	134	201

Non-fatal maternal complications: Teen-agers are at greater risk of toxemia and anemia. Eleven percent of pregnant adolescents are reported to have low hematocrits or hemoglobin values and 9% experience toxemia for an incidence 30% greater than for these same conditions in women of optimal childbearing age; 20-24 years. [13] Other complications do occur in greater proportions among teens, but the numbers are small and insignificant when subject to statistical analysis.

Age versus socio-economic status: It has already been noted that adolescents seem to be more vulnerable to prematurity and toxemia on two counts; age and socio-economic status. It can be demonstrated that good prenatal care and nutrition will virtually eliminate all selective risk factors among teenagers reducing them to that experienced by the 20-24 yr old group, with the exception of the very young who seem vulnerable on an age basis alone. [16] In this latter group, good carescan substantially reduce the incidence of these hazards, but not eliminate their high risk status all together, as can be done for older teens.

When provided optimal care, teenagers of approximately 16 years or more seem no more at risk than others. From a purely biological perspective, then, the older adolescent is fully competent to bear a healthy child and remain healthy herself. Of course this is more a theoretical consideration of a goal not widely obtained than observable, existant fact. The vast majority of teen-agers tend to obtain prenatal care late in the course of pregnancy and do not always observe good dietary practices. It does, however, point to the essential need and value of developing age-oriented programs to catch up these young mothers into comprehensive care as early as one can.

Age appears to become a significant factor in and of itself in those girls who have not yet acquired their full adult weight. Thus reproductive competence needs to be measured in biological rather than chronological terms. Erkan, Rimer and Stine, [21] in

studying the outcomes of 261 girls under 16 years of age, demonstrated that pregnant adolescents who were less than two years post-menarche were at the greatest risk. This was not evident when factored for age alone. The differential reflects the fact that the normal range of menarche for girls in the United States can be anywhere between 10 and 14 years and occurs just as the velocity of the growth spurt begins to decelerate. Graphing on a chronological basis alone tends to dilute and flatten the incidence of risks because of the wide, normal biological variance from one individual to another which characterizes adolescent growth.

Table 15: Low-birth-weight infants and preeclampsia occuring among mothers under 16 years of age according to post menarcheal status.[21]

	Total # mothers	Infants with low birth weight		Mothers with pre-eclampsia	
		#	%	#	%
Mothers 24 months post menarche or less	124	39	31.4	23	18.5
Mothers over 24 months post menarche	157	22	16.0	15	10.9

Summary biological risks: Adolescent mothers are particularly at greater risk of bearing a premature infant and of experiencing toxemia or preeclampsia. These risks arise from two separate causes; first, developmental age, with girls two years or less post-menarche experiencing higher rates of these complications even when pre-natal care is good; and, second, socio-economic, legal, and cultural factors which collectively conspire to encourage late entry into prenatal care. In this latter instance, adolescents share these increased risks with all mothers who are underprivileged and receive inadequate care. Infants of teen-mothers are more likely to die during their first year of

life than are those born to mothers in their twenties. And infant death rates soar above all others if of third birth order or more.

Social Risks:

Far more impressive than biological risks, in terms of both numbers and magnitude of the problem, are those related to the teen-age mother's quality of life. Few escape the life long consequences in terms of educational and economic deprivation or unstable, unhappy forced early marriages. It is a goal of childrearing in the United States to ultimately produce autonomous offspring who can stand on their own two feet.[2] Childbearing in adolescence seriously impedes this goal. In a never ending cycle, the teenage mother is less likely to finish school, more apt to never work and to subsist at or below the poverty income level, more likely to never marry or have her marriage end in divorce or separation, and more prone to bearing additional children in her adolescent years than if she defers her child bearing until after she completes school.[13,18,19]

Table 16: Percent of adolescent mothers completing high school by age at birth of first child.[18]

Mother's age at birth of first child	Percent graduating from high school
13-15	10.6
16-17	17.5
18-19	38.7
20-21	41.5

Adoption and foster care are not viewed as significant options by contemporary young mothers; 85% of those giving birth to an out-of-wedlock child today chose to retain their infant in their own home or that of a relative.[13]

In a study of 408 New York City mothers one year after the birth of their first child, Presser concluded "to the extent that marriage, schooling and employment are socially advantageous to women, the data indicate that teenage motherhood has negative social consequences."[22]

Table 17: Percent women by age at first birth according to birth planning and selected other variables, New York City 1973-74.[22]

	Age at first birth		
	15-19	20-23	24-29
Did not plan 1st birth	80%	56%	30%
Not high school graduate	67	13	6
Had not worked	61	16	2
Not now married	61	16	8

From a longer range perspective, Furstenberg[23] followed for six years a group of 400 pregnant teenagers in Baltimore, Maryland and compared their outcome with a group of classmates who had not become pregnant in their early years. Only one third of the pregnant adolescents gave birth to an out-of-wedlock child; about half terminated the gestation by an induced or spontaneous abortion; 3% were married at the time of conception; 20% became married shortly after conception and before their first visit to the prenatal clinic; and 25% became married by the time of delivery. At the end of five years, only 36% remained single (although as we shall see, the success of teen marriages is strongly in doubt). In comparison, only 21% of classmate controls were married by the age of 18. Retrospectively, fewer than one in three of the young married mothers would have wed if not pregnant and the balance would have wished to defer this step.

The anticipated poor chances of success for these young marriages was born out by the fact that one in five broke up within one year; one third within two. Only 40% survived beyond six years. The rate of marital breakup among classmates was only half as great. Young separated mothers were also unlikely to seek divorce as they did not anticipate marrying again.

A particularly striking factor in Furstenberg's study was that young mothers were much more likely than their classmates to have two or more children within six years. The increased health and social risks of this set of circumstances has already been noted.

Table 18: Percent of Adolescent mothers and classmate controls who became pregnant during the period between 1966 and 1972 by number of pregnancies. [23]

# pregnancies	Adolescent mothers	Classmates
0	0	36
1	33	39
2	37	19
3	20	3
4 or more	10	3

The consequences of dropping out of school, unstable early marriages and repeat pregnancies are that young mothers are much more likely to end up in circumstances of poverty than those who delay childbearing until later years. Trussell [24] has estimated from a survey of 45,000 women that bearing a first child between 13 and 15 years of age confers a 30% chance of ending up in poverty; and that this likelihood increases to 48% if the young mother is black. This is in contrast to 14% of all women and 36% of blacks being poor if they defer childbearing until after age 20 years.

Table 19: Percent of U.S. women living in poverty by age at first birth and race, 1967 [24].

Age at first birth	All races	White	Black
All ages	14.3	12.1	36.7
13-15	30.9	19.8	48.2
16-17	23.2	19.5	38.8
18-19	15.8	13.5	36.5
20-21	14.4	12.6	36.7
≥22	10.5	9.5	29.2

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Summary of social risks: Early child bearing poses serious impediments to a young woman's achievement of autonomy, marital stability and economic security. The younger she is at birth of her first child the more likely she is to drop out of school, bear more children and end up in poverty. Solving the dilemma of an out-of-wedlock child through early marriage also ends up in a high percent of dissolved marital relationships and separations. Divorce may not be resorted to as significant numbers come to view marriage with sufficient mistrust as not to wish risking it again and see no purpose in legal termination.

Psychological factors and risks:

Clear and unique developmental tasks must be achieved during the adolescent years if an individual is to progress from dependent childhood to responsible, mature adulthood and to achieve the capacity for warm, loving altruistic relationships with with husband or wife and child. Erickson [25] classically describes these tasks as emancipation and the establishment of a sexual identity, moral code of behavior, and functional role. Preceding discussions in this paper have addressed the severe limits imposed by child bearing upon functional role in particular. Little attention has been given to the impact on other tasks.

No data is available, for instance, on the degree to which a young mother may experience inhibition of other developmental tasks and whether she can indeed achieve a sound sense of sexual identity or reach an adult level of altruistic caring (the latter has obvious significance for parenting capacity). Many questions remain unanswered in the area of whether developmental arrest, lag or deviation can occur in consequence. Is it possible for the too early assumption of an adult role (motherhood) to interfere with or actually block resolution of normal adolescent conflicts? Certainly the requirements

of motherhood severely restrict the type of activities teenagers need to experience in the successful pursuit of maturation. To what degree does early parenthood impede emancipation and induce a psychological (as well as social) inability to complete high school or achieve economic stability? These may be important and heretofore uncounted factors in seeking solutions.

To what extent is the young mother's emerging capacity for altruistic nurturing inhibited by the sudden demands of child care when she, herself, is still narcissistically oriented in seeking her final identity and securing a necessary sense of self-esteem? And what effect does this have upon the child? Does early motherhood result in a greater likelihood of an emotionally deprived and troubled child? of emotional and/or physical abuse?

One is tempted to believe that adolescent parenthood subjects both mother and child to the potential for serious developmental and psychological deprivations. Empirically this appears to be so. However, it must be subject to rigid scrutiny before this can be said to be established fact.

Nor have we given much consideration to the concept that for many adolescents pregnancy is a solution to a much more painful situation. As noted in earlier discussions, not all adolescents become pregnant solely out of miscalculation or mistake. For many there are both conscious and unconscious underlying factors. Admittedly, electing to become pregnant is inevitably a poor choice for any teen; but it may well be perceived as still better than feeling unloved, unwanted, or unfeminine; or trapped in a difficult situation at home or school or in the limbo of adolescence. Considerable research is still needed in definition of these unconscious factors which makes pregnancy and early motherhood more preferable than that which life has to offer without such an event.

Definition of the problem and solutions:

Solutions to adolescent pregnancy focus on five different goals. First is primary prevention of both initial and subsequent pregnancies. This requires the comprehensive sex education of children as well as adolescents for responsible, planned parenthood; it must include concepts of fertility and birth control as well as the discussion of various options and their respective consequences in an open, non-prejudicial forum.[26] The ready availability of contraceptives for sexually active teens is also necessary and includes mechanical, chemical and hormonal methods in preference to the far less effective methods of rhythm or withdrawal. Prevention also will include access to contraceptive methods, services and supplies under those conditions which adolescents will accept; e.g. [illegible]tiality and on their own consent in settings with few institutional barriers, little [illegible]y, minimal cost and rendered by professionals trained in adolescent health.

[illegible] is the provision of the option of pregnancy termination. While hardly [illegible]rable choice under any circumstances and morally impermissable for some, it still is incontestable that giving birth to a child bears significant biological risks and serious social and emotional consequences for the growing and still maturing teenager whose own life has yet to fully begin.

Third is the early introduction of optimal nutrition and prenatal care for the adolescent who elects to bear her child. This requires the development of special comprehensive and interdisciplinary services to meet her unique developmental and biological needs. Traditional systems of prenatal care for adults has time and again proved insufficient. Attention particularly needs to be given to providing acceptable access to services for early pregnancy detection. As with contraception, this requires a setting which is non-judgemental and to which the teenager will readily come assured of confidentiality, understanding, empathy and support. While sooner or later parents not only should, but

will have to know, initial access must be on the girl's own consent lest she will delay care to her and her child's detriment. Once pregnancy is established, comprehensive and ongoing care coupled with social, emotional, educational and economic support are essential to minimize inherent risks.

Fourth is continuing support of the young mother once she has given birth. Too often programs for pregnant adolescents termtnate at this point, leaving the girl to her own devices. The introduction of contraception, the provision of alternate child care resources to enable the teenager to return to school or vocational training, economic support, psychological services in encouraging continued emotional development, opportunities for normal adolescent activities, the teaching and encouragement of parenting skills, and attention to supporting the integrity of any marriage that may have taken plac[redacted] all essential. [28]

Fifth and most important, is the provision of alternatives to childbearing for those youngsters who appear at risk through being unable to find a sense of purpose, meaning or [redacted]esteem in any other way. Society needs to carefully examine its view and purposes for adolescents and to define a specific, significant role within families and community. Too often teen-agers are kept in a state of limbo, expected to conform to the dependency requirements of an earlier childhood stage in school and at home, yet to act like adults. The confusion is inherent in the mixed message which says "Do what I tell you to, but do it as if you were grown-up". Teenagers need to be needed and wanted, for who the are, rather than what adults think they should be. Even if they sometimes sorely try their parents' souls in the rebellious processes of maturation, their unique developmental nature can not be denied. It is like putting square pegs in round holes, an impossible task.

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Senator RIEGLE. Ms. Wolcott?

Ms. WOLCOTT. I thank you for the opportunity to testify on S. 2910.

I am Ilene Wolcott, project director of the Women and Health Roundtable, a coalition of women's and health-related organizations concerned with increasing the responsiveness of Federal policy to women's health concerns. I am testifying today on behalf of Women and Health Roundtable participants, The Federation of Organizations for Professional Women, the Women's Equity Action League, and the National Women's Political Caucus.

The Federation of Organizations for Professional Women, founded in 1972, is a national association of 100 affiliated organizations committed to attaining equal opportunity for women and improving the impact of public policy on women.

The Women's Equity Action League is a national women's rights organization founded in 1968 for the purpose of promoting the advancement of women through passage of legislation to improve woman's status.

The National Women's Political Caucus, started in 1971, is a 30,000-member multipartisan organization dedicated to increasing the numbers of women in government and to promoting public policies that accurately reflect women's rights and concerns.

S. 2910 has been introduced to establish a program to coordinate Federal, State, and community-based services to:

> Prevent initial and repeat pregnancies among adolescents, to provide care to pregnant adolescents, and to help adolescents become productive independent contributors to family and community life.

We commend the administration's objectives and its commitment to providing comprehensive programs to assist young mothers and their children and to help prevent unwanted adolescent pregnancies. We are concerned, however, that the title and intent of the legislation may be misleading as it implies that equal emphasis will be placed on preventing pregnancies and on providing services and treatment for pregnant teens.

We are all familiar with the troubling facts and figures regarding teenage pregnancies, and the tragic, adverse, social, emotional, and physical consequences associated with too early parenthood.

And 11 million teenagers between the ages of 15–19 are estimated to be sexually active—40 percent of all girls and 60 percent of all boys in this age range.

In 1976, 1 million or 1 out of 10 teenagers aged 15–19 became pregnant.

Of these 1 million, 600,000 gave birth.

Of these births, 215,000 were to teens aged 15–17 12,000 were to teens under age 15.

Young teenage mothers and their babies face significantly higher health risks than those that postpone childbearing for a few years.

Also 8 out of 10 young teen mothers never complete high school. Early motherhood is associated with lower economic status—one-half of all mothers in AFDC families had their first child in early adolescence.

PROVISION OF COMPREHENSIVE SERVICES

The legislation would authorize $30 million the first year to coordinate and link existing services and an additional $30 million to supplement existing services and to promote: "Innovative, integrated, and comprehensive approaches to the delivery of such services."

These services could include: Family planning, sex education, and parenthood counseling, vocational, employment, mental health and nutrition counseling and education, residential and prenatal and postpartum care.

Secretary Califano testified that the estimated cost of providing such comprehensive services to a young woman, her infant, and male partner would average $750 a year. We are concerned that this cost estimate only considers the administrative expenses related to coordinating services, but does not consider the cost of providing actual services. The comprehensive services vaguely outlined in the bill are expensive. The most essential component, day care, is not specifically mentioned, yet without day care, a teen mother cannot take advantage of many of the other necessary programs.

We also question whether adequate services and programs to assist teen mothers and fathers currently exist in meaningful enough numbers to make these linkages a workable strategy.

Expanded coordination of services will increase demand for such services, demand that could overwhelm existing programs. As demand escalates, the cost of providing services will increase. We question whether the funding authorized by this legislation addresses these contingencies.

In addition, we believe there is a need to define more precisely, but not rigidly, the scope and definition of comprehensive services. For example, how many services will a demonstration project have to offer to qualify for a grant? Will funding cover the salary of a social worker or nurse assigned to a school or a welfare worker trained to refer teens to coordinated programs?

Little consideration appears to be given to the fact that comprehensive services need to be provided to each mother and infant—and hopefully father—for an extended time period, not just during the 9 months of pregnancy and a short postpartum period. Young girls who are counseled into accepting and anticipating motherhood will need medical care, day care, employment and emotional supports for many months, even years if they are young teens.

Young teens may accept and anticipate motherhood but babies are demanding; they interfere with the normal pursuits of adolescents. Babies become ill, want constant attention, need constant care and grow older. Babysitters are expensive, clothes, toys, and outings are expensive. Will the essential and supportive services outlined in the legislation be available over the years to these teen mothers?

These factors need to be considered when young pregnant teens, some who are barely out of childhood themselves, are encouraged to carry through an often unwanted and mistimed pregnancy. We are not assured that this legislation addresses the full consequences that bearing and caring for children create in teenagers.

PREVENTION

Prevention of initial and repeat pregnancies is the second objective of this legislation. This goal appears to be a very weak link in the chain of suggested strategies.

Testimony presented at hearings on Title X of the Public Health Service Act stated that family planning services failed to reach over 1.5 million teens considered "at risk" of becoming pregnant. Of these over 1 million teenagers not receiving organized family planning services, 800,000 live in areas where access and availability to services is limited. A recent Johns Hopkins University study revealed that current use of birth control by teens prevents an estimated 680,000 premarital pregnancies annually. Increasing access and availability of contraceptive services to teens will be one way this legislation can prevent teenage pregnancies.

However, although the use of contraceptives by teens is on the rise, over 30 percent of sexually active teens do not use birth control. Reasons for this include a lack of information about pregnancy, reproduction, and contraception, guilt and embarrassment in seeking information, as well as a lack of access to services. To ameliorate this situation, programs that are specifically tailored to the unique needs and concerns of teen men and women must be supported by this bill.

Sex education and counseling programs must be a major component of any pregnancy prevention strategy. This legislation is remiss in not stressing such programs more forcefully. Education for responsible parenting, a concern of this bill, is an essential objective, but education programs must also include effective counseling for responsible sexual activity for those 11 million sexually active teenagers. One can prevent pregnancy, and encourage responsible parenting, but it is unrealistic to assume the trend toward increased sexual activity among teens will be substantially reversed.

Sex education programs that provide straightforward balanced information on sexuality, reproduction and fertility control—that encourage adolescent self-discipline, but also accept the realities of adolescent sexuality need to be supported. Relevant sex education programs combined with sensitive family planning services can be the best preventive measures this legislation can support to achieve its aim of reducing the incidence of teenage pregnancies.

To be effective, prevention services must include provisions for early pregnancy testing and counseling and referral to abortion services to assure that teenagers can make informed decisions regarding the outcome of their pregnancies.

Although we appreciate that abortion is not accepted by all individuals, it is a serious omission to discuss teenage pregnancy and not include counseling and referral for abortion among the options available to pregnant teens. For many young teens, abortion is an alternative, another way to reverse, in Secretary Califano's words, "the wrenching disruption of life and education caused by unwanted pregnancy and its consequences."

A final, but critical, concern from our perspective is the far greater negative impact that early, mistimed, and unwanted pregnancies have on women than on men.

I would like to comment on a statement made by a witness earlier this morning. If there is to be a minimum age designated for childbearing, there should also be a minimum age designated for fathering a child.

Sexual mores and behavior are influenced by the values and expectations of the community and larger society. How young women view their role in society affects pregnancy and childbearing behavior and attitude. Studies have indicated that some young women have a baby in order to feel needed or to acquire a purpose or role in life. A society that encourages women to limit their expections only to motherhood and childbearing encourages a young girl to accept the idea of being or becoming pregnant even if such a pregnancy will have adverse physical, social, and emotional consequences. Young teenage girls need to be provided with alternatives beyond motherhood to achieve self-validation and a sense of personal worth. To be effective, this legislation must support education and counseling programs that explore these questions.

Thank you again for the opportunity to express our concerns.

The CHAIRMAN. Thank you very much. I understand Ms. Hooks will not be able to present testimony today, however, Ms. Wurf will be speaking on behalf of the Girls Clubs of America.

Ms. WURF. I am the Washington representative of the Girls Clubs of America, speaking here on behalf of Mrs. Hooks, whose transportation difficulties prevented her from making it in time for this hearing. She would have been here as a member of the National Board of Girls Clubs of America and as a person of long experience in counseling and as an educator in working with adolescents, and a person with deep interest in this legislation.

I am happy, however, to present the view of our organization, which is very concerned with this issue. Just 4 weeks ago we sponsored in cooperation with the Johnson Foundation a seminar entitled, Today's Girls: Tomorrow's Women, where we brought together nationally prominent individuals in the fields of human sexuality and adolescent medicine, with leaders of women's and girl's organizations, public policymakers, and media representatives. We were pleased Dr. Hoffman was one of the experts with us on that occasion.

I would like to make clear that the Girls Clubs is not just a national advocacy organization for girls. It is also a direct service organization. In neighborhood facilities, our professionals and volunteers have daily contact with girls from the ages of 6 to 18. About one-quarter million girls are members of local Girls Clubs. In our most recent survey in 1977, 92 percent of these were girls from families with incomes under $10,000 a year and 49 percent represented minority groups. This is a population most adversely affected by teenage pregnancy and for whom the fewest health and social services exist.

In a number of communities where there is a Girls Club, our agency has taken a leadership role in serving some of the needs of pregnant teenagers and in working with young women in prevention programs and education programs. These kinds of programs are locally determined.

They are not nationally developed and then laid on to the local community.

They come out of the needs of the community and they range from discussion and rap groups to housing and operation of alternative schools in cooperation with local school and health authorities.

We will submit program descriptions for the record of several of these kinds of programs.

We are in total support of the statement of purpose of S. 2910, but we would like to comment on several ways in which we think the bill might be strengthened.

First; we believe emphasis should be on primary prevention. Along with all major youth-serving agencies, we believe in the value of services leading to positive youth development, rather than services aimed at rehabilitation or preventing repetition of harmful behavior. The emphasis in this bill seems heavily directed at preventing repeat pregnancies and to be related to provision of health services. We believe the question is a larger one—that girls, and boys as well, need positive programs where they develop a sense of self-worth, become aware of their own responsibility for the direction of their lives, learn to make decisions in full understanding of the consequences, and become aware of the range of options now open to them. Part of such programs may be directly based on dissemination of family planning information, but the broader context is crucial for positive development from young girl to self-reliant woman. Successful programs in GCA, for example, dealing with this area, place heavy emphasis on developing the skills for competent decisionmaking. Another major element is the provision of positive role models and the availability of individual support and counseling.

Second; voluntary multi-purpose agencies as deliverers of service: Much of the language of the legislation suggests it was written with a clinic in mind as the model for services. But in general, girls will only go to the clinic when they need specific help—probably to get help with their pregnancy. Services need to be available to young people who may originally come seeking other services, such as vocational or legal counseling, social services, or recreation as Secretary Califano states in his testimony to your committee on June 14. To fill that need, the legislation should recognize the value of working with voluntary organizations like the Girls Clubs, where girls come to be in a place that belongs to them, to learn specific skills to get needed counseling, for fun, for help, and to feel important. The environment of trust and support that exists will not easily be duplicated by a single-purpose agency, whether Government or private, however well-intentioned. The community-supported voluntary agency was a part of community life before any given Government program, and will be there after Government priorities shift.

Third; funding set-asides: Our past experience working with HEW indicates that unless specific language appears in the legislation showing congressional intent, the voluntary sector is not thought of as a provider of services of this sort. The tendency is to work through the public agencies of the State, and through them, with the cities. However, if there is a serious interest in involving the broader purpose agencies which serve young people throughout the country in so many ways, it is essential that a portion of funding be set aside to encourage their participation.

Precedent for this can be found in the Juvenile Justice and Delinquency Prevention Act of 1974 as amended in 1977. In the amendments, the percentage of special emphasis funds set aside for voluntary agency funding was changed from at least 20 percent to at least 30 percent to continue to attract the resources of the voluntary sector to work with young people at risk. I should say that since the passage of that legislation, the number of Girls Clubs who work with girls on referral from the courts or provide alternative services to status offenders has tripled.

Fourth; public-private cooperation: There is also no specific requirement that public agencies applying for grants under this act coordinate efforts with the private sector. It has been our experience that the most effective service delivery systems and community programs are those in which the public and private sectors have a partnership.

Legislation, such as the Juvenile Justice and Delinquency Prevention Act of 1974, amended 1977, speak to this partnership and use specific legislative language to invite participation of the voluntary sector. This has brought response from agencies such as Girls Clubs. The large youth-serving agencies with the capacity to reach millions of young people in thousands of communities, can, and must, be involved in any effort to impact upon a problem as serious as this one has become.

Fifth: A point already made by others is that of match provisions. If there is a serious intent to involve voluntary agencies, a 70–30 match renders that program almost impossible. Voluntary agencies have very great difficulty raising the funds to keep going, fuel bills go up, all other costs go up, but philanthropic dollar does not seem to become inflated. So we would suggest that there be either an in-kind match permitted on the 90–10 formula suggested, or that full Federal funding be available for start-up costs, providing new services to existing agencies.

Sixth: We speak to the question of adequate funding, primarily from the perspective of the importance of primary prevention. But because direct services are so greatly needed, if there is limited funding, we believe based on experience that money will go to provision of needed services rather than to primary prevention. You need to break the cycle at an earlier age. A substantially larger authorization is needed to assure initiation of prevention programs at the same time that basic services are provided.

Finally: The matter of coordination. Title II of the act speaks to intent to coordinate programs. This was also highlighted in Secretary Califano's introduction of the legislation.

But there is almost no language that suggests how this is to be done. We think this is too important a matter to be left to regulations. There are too many examples of uncoordinated efforts and initiatives for us to believe that it will be effective, unless there is specific direction in the legislation. This is particularly important when you think of all the funds and other kinds of resources available through HEW, which will not be brought to bear together unless there is real leadership in coordination and clout, presumably out of the Secretary's office.

The only specificity in Title II is the requirement that a State coordinate any activity funded under this legislation with funded programs of any local grantees. That hardly suffices to insure a level of coordination of activity that would make a difference to the adolescent facing life decisions affecting the possibility of pregnancy, or the life of a baby about to be born to a child.

We have brought forward these points: Greater emphasis on primary prevention; involvement of voluntary agencies; set-aside funding to achieve that involvement; public-private cooperation; changed match provisions; adequate funding; significant coordination—because we believe the purposes of the act are so important.

We hope our suggestions will be seriously considered as we believe they will make the legislation more useful to the young people in need of help. If an Adolescent Health, Services, and Pregnancy Prevention Act of 1978, is passed which is too general, focused on medical services or lacking any teeth in the coordination function, it will be easy to say that the problem has been addressed. Greater breadth as well as greater specificity is needed to change things for the better in this very sensitive urgent social situation.

We thank you for this opportunity to speak to this issue, and we will be providing for the record, some examples of programs that our particular agency carries out in the areas of peer counseling, primary prevention, and the use of our facility as an alternative school or as a coordinating base for existing community services.

Thank you.

[The prepared statements of Ms. Wolcott and Ms. Hooks follow:]

2000 P Street N.W., Suite 403 • Washington, D.C. 20036 • 202/466-3545

STATEMENT OF ILENE WOLCOTT
CONCERNING THE ADOLESCENT HEALTH, SERVICES, AND PREGNANCY PREVENTION AND CARE ACT OF 1978, BEFORE THE SENATE COMMITTEE ON HUMAN RESOURCES ON BEHALF OF THE WOMEN AND HEALTH ROUNDTABLE FOR THE FEDERATION OF ORGANIZATIONS FOR PROFESSIONAL WOMEN, THE WOMEN'S EQUITY ACTION LEAGUE AND THE NATIONAL WOMEN'S POLITICAL CAUCUS

JULY 12, 1978

Mr. Chairman, members of the Committee, thank you for the opportunity to testify on the Adolescent, Health Services, and Pregnancy Prevention and Care Act of 1978. I am Ilene Wolcott, Project Director of the Women and Health Roundtable, a coalition of women's and health related organizations concerned with increasing the responsiveness of federal policy to women's health concerns. I am testifying today on behalf of Women and Health Roundtable participants, The Federation of Organizations For Professional Women, The Women's Equity Action League, and the National Women's Political Caucus.

The Federation of Organizations For Professional Women, founded in 1972, is a national association of 100 affiliated organizations committed to attaining equal opportunity for women and improving the impact of public policy on women.

The Women's Equity Action League is a national women's rights organization founded in 1968 for the purpose of prompting the advancement of women through passage of legislation to improve women's status.

The National Women's Political Caucus, started in 1971, is a 30,000 member multi-partisan organization dedicated to increasing the numbers of women in government and to promoting public policies that accurately reflect women's rights and concerns.

S. 2910, has been introduced to establish a program to coordinate federal, state, and community based services to, "prevent initial and repeat pregnancies among adolescents; to provide care to pregnant adolescents, and to help adolescents become productive independent contributors to family and community life."

We command the Administration's objectives and its committment to providing comprehensive programs to assist young mothers and their children and to help prevent unwanted adolescent pregnancies. We are concerned, however, that the title and intent of the legislation may be misleading as it implies that equal emphasis will be placed on preventing pregnancies and on providing services and treatment for pregnant teens.

We are all familiar with the troubling facts and figures regarding teen-age pregnancies, and the tragic, adverse social, emotional, and physical consequences associated with too early parenthood.

- Eleven million teen-agers between the ages of 15-19 are estimated to be sexually active- 40% of all girls and 60% of all boys in this age range
- In 1976, 1 million or 1 out of 10 teen-agers aged 15-19 became pregnant.
- Of these 1 million, 600,000 gave birth.
- Of these births,
  215,000 were to teens aged 15-17,
  12,000 were to teens under age 15.

- Young teen-age mothers and their babies face significantly higher health risks than those that postpone childbearing for a few years.
- Eight out of ten young teen mothers never complete highschool.
- Early motherhood is associated with lower economic status- half of all mothers in AFDC families had their first child in early adolescence.

PROVISION OF COMPREHENSIVE SERVICES

The legislation would authorize 30 million dollars the first year to coordinate and link existing services and an additional 30 million to supplement existing services and to promote "innovative, integrated, and comprehensive approaches to the delivery of such services." These services could include: family planning, sex education and parenthood counseling, vocational,employment,mental health, and nutrition counseling and education, residential, and prenatal and post-partum care.

Secretary Califano testified that the estimated cost of providing such comprehensive services to a young women, her infant, and male partner would average $750.00 a year. We are concerned that this cost estimate only considers the administrative expenses related to coordinating services,but does not consider the cost of providing actual services. The comprehensive services vaguely outlined in the bill are expensive. The most essential component, daycare, is not specifically mentioned,yet without daycare, a teen mother cannot take advantage of many of the other necessary programs.

We also question whether adequate services and programs to assist teen mothers and fathers currently exist in meaningful enough numbers to make these linkages a workable strategy.

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Expanded coordination of services will increase demand for such services ,demand that could overwhelm existing programs. As demand escalates, the cost of providing services will increase . We question whether the funding authorized by this legislation addresses these contingencies.

In addition, we believe there is a need to define more precisely, but not rigidly, the scope and definition of comprehensive services. For example, how many services will a demonstration project have to offer to qualify for a grant? Will funding cover the salary of a social worker or nurse assigned to a school or a welfare worker trained to refer teens to coordinated programs?

Little consideration appears to be given to the fact that comprehensive services need to be provided to each mother and infant (and hopefully father) for an extended time period, not just during the nine months of pregnancy and a short post-partum period. Young girls who are counseled into accepting and anticipating motherhood will need medical care, daycare, employment, and emotional supports for many months, even years if they are young teens. Young teens may accept and anticipate motherhood, but babies are demanding; they interfere with the normal pursuits of adolescents. Babies become ill, want constant attention, need constant care, and grow older. Babysitters are expensive, clothes, toys, and outings are expensive. Will the essential and supportive services outlined in the legislation be available over the years to these teen mothers? These factors need to be considered when young pregnant teens, some who are barely out of childhood themselves, are encouraged to carry through an often unwanted and mistimed pregnancy. We are not assured that this legislation addresses the full consequences that

bearing and caring for children create in teen-agers.

PREVENTION

Prevention of initial and repeat pregnancies is the second objective of this legislation. This goal appears to be a very weak link in the chain of suggested strategies.

Testimony presented at hearings on Title X of the Public Health Service Act stated that family planning services failed to reach over 1.5 million teens considered "at risk" of becoming pregnant. Of these over one million teen-agers not receiving organized family planning services, 800,000 live in areas where access and availability to services is limited. A recent John Hopkins University study revealed that current use of birth control by teens prevents an estimated 680,000 premarital pregnancies annually. Increasing access and availability of contraceptive services to teens will be one way this legislation can prevent teen-age pregnancies.

However, although the use of contraceptives by teens is on the rise, over 30% of sexually active teens do not use birth control. Reasons for this include a lack of information about pregnancy, reproduction, and contraception, guilt and embarrassment in seeking information, as well as a lack of access to services. To ameliorate this situation, programs that are specifically tailored to the unique needs and concerns of teen men and women must be supported by this bill.

Sex education and counseling programs should be a major component of any pregnancy prevention strategy. This legislation is remiss in not stressing such programs more forcefully. Education for responsible parenting, a concern of this bill, is an essential objective, but education programs must also include effective

counseling for responsible sexual activity for those 11 million sexually active teen-agers. One can prevent pregnancy and encourage responsible parenting, but it is unrealistic to assume the trend toward increased sexual activity among teens will be substantially reversed.

Sex education programs that provide straightforward balanced information on sexuality, reproduction, and fertility control- that encourage adolescent self-discipline, but also accept the realities of adolescent sexuality need to be supported. Relevent sex education programs combined with sensitive family planning services can be the best preventive measures this legislation can support to achieve its aim of reducing the incidence of teen-age pregnancies.

To be effective prevention services must include provisions for early pregnancy testing and counseling and referral to abortion services to assure that teen-agers can make informed decisions regarding the outcome of their pregnancies.

Although we appreciate that abortion is not accepted by all individuals, it is a serious omission to discuss teen-age pregnancy and not include counseling and referral for abortion among the options available to pregnant teens. For many young teens, abortion is an alternative, another way to reverse, in Secretary Califano's words, " the wrenching disruption of life and education caused by unwanted pregnancy and its consequences."

A final,but critical, concern from our perspective is the far greater negative impact that early, mistimed, and unwanted pregnancies have on women than on men. Teen fathers generally assume minimum, if any, emotional or financial support for the children they beget.

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Sexual mores and behavior are influenced by the values and expectations of the community and larger society. How young women view their role in society affects pregnancy and childbearing behavior and attitude. Studies have indicated that some young women have a baby in order to feel needed or to acquire a purpose or role in life. A society that encourages women to limit their expectations only to motherhood and child bearing encourages a young girl to accept the idea of being or becoming pregnant even if such a pregnancy will have adverse physical, social, and emotional consequences. Young teen-age girls need to be provided with alternatives beyond motherhood to achieve self-validation and a sense of personal worth. To be effective, this legislation must support education and counseling programs that explore these questions.

Thank you again for the opportunity to express our concerns.

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Statement by

Frances Hooks,

National Board Member

on behalf of

Girls Clubs of America

before

Senate Committee on Human Resources

July 12, 1978

Mr. Chairman, I am Frances Hooks, a member of the National Board of Girls Clubs of America, a national voluntary youth-serving organization. I am pleased to be here today to participate in these hearings and present our views on what we consider to be an important legislative proposal, the "Adolescent Health Services and Pregnancy Prevention and Care Act of 1978." We believe that the Committee's understanding of the importance of these issues is demonstrated by scheduling this day of hearings to allow representatives of organizations concerned with services to young people to offer their views in this matter.

The proposed legislation attempts to address what has become a critical issue in the United States. Just four weeks ago, at a seminar, "Today's Girls: Tomorrow's Women", sponsored by the Girls Clubs of America in cooperation with the Johnson Foundation, nationally prominent individuals in the fields of human sexuality and adolescent medicine were brought together with leaders of women's and youth organizations, public policy makers and media representatives. They presented the alarming statistics and serious lack of resources that are also well documented in Section 2 (a) of the Act, the findings on which this legislation is based. Girls Clubs sponsored this seminar to highlight the problems facing adolescent girls today in the belief that serious national attention must be paid to these problems. We acted also to stimulate the development of new services and the redirection of existing services for girls.

As background for the Committee, I would like to make clear that Girls Clubs of America is a direct service voluntary agency as well as a national advocate for the needs and interests of all girls.

In 258 separate facilities, Girls Clubs' professionals and volunteers are in daily contact with girls from the ages of six to eighteen. They have direct contact with the realities of adolescent pregnancy and its effect upon the lives of young women. Almost a quarter of a million girls are members of Girls Clubs of America. In 1977, 92% were from families with annual incomes under $10,000; 49% represented minority groups. This is the population most adversely affected by a teenage pregnancy and for whom the fewest health and social services exist.

In several of the approximately 125 separate communities in which Girls Clubs are located, our agency has taken a leadership role in serving some of the needs of the pregnant teenagers and in working with other young women in education and preventive programs.

The individual programs range from discussion and rap groups to the housing and operation of alternative schools in cooperation with local school and health authorities. Several short program descriptions of relevant Girls Clubs projects will be submitted for the record.

I want to be clear that we are in total agreement with and support of the statement of purpose of this Act.

(Sec. 2 (b)):

(1) to establish better linkage among existing programs in order to expand and improve the availability of, and access to, needed comprehensive community services which assist in preventing unwanted initial and repeat pregnancies among adolescents, enable pregnant adolescents to obtain proper care and assist pregnant adolescents and adolescent parents to become productive independent contributors to family and community life;

(2) to expand availability of community services that are essential to that objective; and

(3) to promote innovative, comprehensive, and integrated approaches

to the delivery of such services.

We do believe that the proposed legislation could be greatly improved to make more of an impact on the problem. I shall briefly present seven points:

1. Greater emphasis should be given to primary prevention.
2. The use of voluntary multi-purpose agencies as potential service deliverers should be recommended to meet the level of need.
3. A portion of the funding should be set aside for private not-for-profit agencies to facilitate their cooperation.
4. The value of public private cooperation in the delivery of service should be recognized in the legislation.
5. In-kind match should be permitted for non-profit agencies.
6. Adequate funds should be provided.
7. The means of coordination within HEW, as well as within States, needs to be spelled out.

Primary Prevention

Along with all major youth-serving agencies, we believe in the value of services leading to positive youth development, rather than services aimed at rehabilitation or preventing repetition of harmful behavior. The emphasis in this bill seems heavily directed at preventing repeat pregnancies and to be related to provision of health services. We believe the question is a larger one -- that girls and boys as well need positive programs where they develop a sense of self-worth, become aware of their own responsibility for the direction of their lives, learn to make decisions in full understanding of the consequences, and become aware of the range of options now open to them. Part of such programs may be directly based on dissemination of family planning information, but the broader context is crucial for positive development from young girl to self-reliant woman. Successful programs in GCA, for example, dealing with this area, place heavy

emphasis on developing the skills for competent decision making. Another major element is the provision of positive role models and the availability of individual support and counseling.

Voluntary Multi-Purpose Agencies as Deliverers of Service

Much of the language of the legislation suggests it was written with a clinic in mind as the model for services. But in general, girls will only go to the clinic when they need specific help -- probably to get help with their pregnancy. Services need to be available to young people who may originally come "seeking other services, such as vocational or legal counseling, social services, or recreation" as Secretary Califano states in his testimony to your Committee on June 14. To fill that need, the legislation should recognize the value of working with voluntary organizations like the Girls Clubs, where girls come to be in a place that belongs to them, to learn specific skills, to get needed counseling, for fun , for help, and to feel important. The environment of trust and support that exists will not easily be duplicated by a single-purpose agency, whether government or private, however, well-intentioned. The community-supported voluntary agency was a part of community life before any given government program and will be there after government priorities shift.

Funding Set-Aside

Our past experience working with HEW indicates that unless specific language appears in the legislation showing Congressional intent, the voluntary sector is not thought of as a provider of services of this sort. The tendency is to work through the public agencies of the state, and through them, with the cities. However, if there is a serious interest in involving the broader purpose agencies which serve young people throughout the country, in so many ways, it is essential that a portion of funding be set aside to encourage their participation.

Precedent for this can be found in the Juvenile Justice and Delinquency Prevention Act of 1974 as amended in 1977. In the Amendments, the percentage

of Special Emphasis Funds set aside for voluntary agency funding was changed from "at least 20%" to "at least 30%" to continue to attract the resources of the voluntary sector to work with young people at risk. I should say that since the passage of that legislation, the number of Girls Clubs who work with girls on referral from the Courts or provide alternative services to status offenders has tripled.

Public-Private Cooperation

There is also no specific requirement that public agencies applying for grants under this Act coordinate efforts with the private sector. It has been our experience that the most effective service delivery systems and community programs are those in which the public and private sectors have a partnership.

Legislation, such as the Juvenile Justice & Delinquency Prevention Act of 1974, amended 1977, speak to this parternership and use specific legislative language to invite participation of the voluntary sector. This has brought response from agencies such as Girls Clubs. The large youth serving agencies with the capacity to reach millions of young people in thousands of communities can and must be involved in any effort to impact upon a problem as serious as this one has become.

Match Provisions

The programs and requirements specified in Title I of the Act are not likely to lead to agencies such as ours qualifying as the participating agency because of the requirement outlines in SEc. 103 (c) (2). Any specification of cash matching funds makes it extremely difficult for private agencies to participate. A Girls Clubs, however, is potentially a viable agency to coordinate the priority services mentioned in the Act because of its customary location in what will most likely be target communities, its ongoing relationship with the young women, its understanding

of and familiarity with the need for multi-disciplinary services. However, in-kind match or full federal funding is required. Voluntary agencies are deeply affected by the increased cost of fuel and other supplies, and the philanthropic dollar may be the only item in our economy not showing the results of inflation.

Adequate Funding

It is from the perspective of the importance of primary prevention that we address the matter of adequate funding. We do not think the proposed authorization is adequate. Coordination and innovation are important and necessary in any effective program initiative. However, in most communities with which we are familiar, there is a sorry lack of the most basic servcies, -- services necessary for the health and future of the young woman and her child, much less servcies to prevent young women from having got pregnant the first time. This, in our opinion, means that there will be little attention paid to proposals for any kind of prevention services because of the immediacy of the needs of the already pregnant adolescents, needs for education, day-care, and other support services in addition to direct medical care. And these needs are currently not being met. Substantially larger authorization is needed to insure the initiation of prevention programming at the same time that basic services are provided.

Coordination

Title II of the Act speaks to the intent to coordinate programs. This aspect of the program is also highlighted in Secretary Califano's statement released at the time of introduction of the legislation. The Secretary cites the availability of funds from several programs that are supposed to support the goals of this Act and therefore make the funding more adequate for critical program needs. However, the legislation does not spell out the mechanism of this coordination. This is, in our opinion, too important an issue to be left to regulations. There are too many examples of uncoordinated

program initiatives for us to believe that this will be done without specific legislative direction.

This is particularly important when one realizes the significant funds and other resources that might be made available through the Health, the Education and the Welfare Departments of HEW if real leadership and coordination with clout were available at the level of the Secretary's Office.

The only specificity in Title II is the requirement that a state coordinate any activity funded under this legislation with funded programs of any local grantees. That hardly suffices to insure a level of coordination of activity that would make a difference to the adolescent facing life decisions affecting the possiblity of pregnancy, or the life of a baby about to be born to a child.

* * *

We have brought forward these points: greater emphasis on primary prevention; involvement of voluntary agencies; set-aside funding to achieve that involvement; public-private cooperation; changed match provisions; adequate funding; significant coordination - because we believe the purposes of the Act are so important.

We hope our suggestions will be seriously considered as we believe they will make the legislation more useful to the young people in need of help. If an Adolescent Health, Services and Pregnancy Prevention Act of 1978 is passed which is too general, focussed on medical services or lacking any teeth in the coordination function, it will be easy to say that the problem has been addressed. Greater breadth as well as greater specificity is needed to change things for the better in this very sensitive urgent social situation.

Girls Club of Lynn, Massachusetts

Unit on Teen Pregnancy

The unit on teen pregnancy was designed to provide realistic, peer-oriented sex education to the girls in our teen program, and to acquaint them with resources and services in the community which offer family planning and information, and support for unplanned pregnancies. The cost was minimal, due to donated resources of Catholic Family Services and the North Shore Family Planning Clinic. The group leader was funded in part by a grant from the Hyams Family Trust, as part of a delinquency prevention approach to teen girls at risk.

The unit grew out of the increasing awareness of staff to the declining age of teen mothers in our community, the lack of adequate birth control and sex deducation programs in the public schools, and the clamour of our teen members for information about sexuality, babies, and motherhood--all subjects ladan with potent attractions and great mis-information. We had earlier run some staff trsining sessions on sexuality in conjunation with the North Shore Family Planning Clinic, a non-sectarian community-based organization. It was apparent that, due to the many white-ethnic Catholic families we served, we should seek out Catholic Services' resources, in order to secure parental accsptance. We also decided to invite teens who had experisnced unplanned pregnancies, to "tell it like it was" to their peers. No one else could deliver the message so effectively.

The unit consisted of an afternoon special event with a film and invited guests, followed by several rap sessions during regular drop-in hours of the teen program. Ten girls attended, with parental permission. The film, "I'm Seventeen and Pregnant"* was lent to us at no cost by Catholic Family Services, from the Unmarried Mothers Program. The CFS also provided, as volunteer leaders, two young women under the age of twenty-one who had had a baby and kept it, and one who had given up her baby for adoption. After the film the two volunteers shared their experiences openly, frankly, movingly with our group members. In the following weeks, the group leader led several discussions around the issues raised at the special event. The teen resource library began collecting printed materials and a resource file around sexuality and unplanned pregnancy. The unit will be repeated again this year as part of our expanded LEAA-funded program. Its impact can be measured by the following criteria: 1) Many of the original group are experimenting sexually still; yet, not one member of this group has become pregnant, one year later. 2) The expanding resource file, largely from donated and free materials, is now being utilized fully by all teen members.

*Available also through the Children's Home Society of California, 3100 West Adams Blvd., Los Angeles, Calif. 90018 - price $2.00

Girls Club of Memphis, Tennessee

Peer Counseling Program

The club needed a more affective method of providing information and counseling for our participants. We had participated in the National Youthworkers Education Project in Minneapolis and learned of the Teenage Health Consultants program there. When I returned to Memphis, a representative from Planned Parenthood approached us with plans for a pilot program for a Peer outreach program. We worked on revamping the format to make the sessions more appropriate for our girls by brainstorming both with staff and girls for several afternoons.

In order to determine who would be eligible to participate in the program, we chose a rather broad age range (12-18) and asked the Program Directors in our three centers to circulate the program idea. Sixteen girls from our three centers volunteered and helped us work out the most appropriate day and time for our meetings, along with establishing a travel schedule...we only had one van to pick-up everybody from three sections of town.

Our immediate goal was to provide the sixteen participants with intelligent, honest, and current information dealing with sexual helath as it relates to the major aspects of human and social development. Our long range goal is to utilize the knowledge and skills gained by these girls within each of our centers in a Peer Counseling Program. Our interest is to continously integrate new participants into the Peer Counselor sessions so that we provide for ongoing training.

During the ten weeks of formal sessions, held at the Planned Parenthood office, information and educational materials were used extensively. All of us worked very hard to really listen to one another and verbalize our feelings. The last session became an evaluative reflection upon the last nine weeks and we determined that we needed to continue our sessions with a new focus...the formation of an internal support system for our peer counselor group with strong emphasis on interpersonal communication as the girls began acting as peer counselors within the clubs.

This program has operated thus far totally within the context of our present budget. One staff person was utilized to act as transporter and coordinator along with a work-study student who attended the formal sessions and who was responsible for all follow-up contact. The Planned Parenthood staff coordinated the actual sessions....arranging for guest speakers, visual aids, and program details.

The value of this program is multi-faceted. The girls involved grew personally as they were exposed to a wide range of information. Interest in the program was generated as the other girls watched our progress. A sizeable number of agencies provided volunteer input into the actual sessions. The participants determined to continue meeting with emphasis on communication skills and the formation of a core support group to help develop training for more peer counselors. This program served as a successful pilot project and it now is being used as a model developing peer counselor groups within the city.

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Southside Girls Club, Wichita Falls, Texas

"For Girls Only"

At numerous rap sessions with club members, I became aware of broken links of knowledge among these young women. Some of the club members were sexually active, but uneducated in bodily functions. Some members were lacking in knowledge concerning boy-girl relations, aexuality, role playing, as well as grooming and hygenic care. Although most understood what rape was, many did not know the trauma such an event could cause or even how to prevent its occurence. At some of the sessions apprehension was expressed concerning jobs. Few knew where the starting point was and were stiffled before they could begin. From these discussions arose the program, "For Girls Only". It is the product of Miss Pam Weisen, counselor and Probation Officer of Family Court Services of Wichita County and Mrs. Anne Rousey.

After several meetings, Miss Weisen and I decided to present a program on problems of womanhood which would serve to answer some of the questions paramount in the teenage mind. Using the data gathered in sessions with teenagers, we decided to hold a seminar with eight sessions and invite professional persons to lend their expertise to the group. Those who accepted the call were two psychologists, a medical doctor, members of the local cosmetic firms, two members of the distributive education program in Wichita Falls Independent School District, members of the Welfare Department, several business persons within the community. These individuals donated their time and expertise to this project.

Each program provided opportunity for the girls to participate, ask questions, and share feelings and ideas with one another. This was a very strong point because not only were Southside Club members in attendance, but girls from Family Court Services and patients at the State Mental Hospital who had emotional problems but could function with the group. It was found that although these girls had come from varying backgrounds, all had similar worries and concerns. Those who had been in trouble with law enforcement and presently on probation shared experiences with the group. Those suffering from emotional problems shared experiences with the group. Not only did participants gain factual information from the professional advisors, but from their peer group as well. As evidence of the success of the program, attendance at each session was between 32 to 35 teenagers.

The program expense was very little. The guest speakers donated their time. Southside provided equipment and facility. Family Court Services provided the printed program. Refreshments, which were consumed at each session were donated.

FOR GIRLS ONLY

October 7, 1976
7:00 p.m. - 9:00 p.m.
Tracy Minard, Ed.d.
Program Coordinator of the
Childrens & Adolescent Units
Wichita Falls State Hospital
"WHO AM I"

October 14, 1976
7:00 p.m. - 8:00 p.m.
Joe McGraw, PhD
Psychologist
"TEENAGE RELATIONSHIPS"

8:00 p.m. - 9:00 p.m.
Jerry Alexander, D.O.
"WHAT YOU'VE ALWAYS WANTED
TO KNOW ABOUT YOUR BODY
BUT WERE AFRAID TO ASK"

October 21, 1976
7:00 p.m. - 8:00 p.m.
Yvonne Castile
Family Planning Education
Representative
Family Planning Clinic
"BIRTH CONTROL" -- Film

8:00 p.m. - 9:00 p.m.
Patsy Baggett, Supervisor
Adoption & Foster Home Placement
Wichita County Family Court Services
"ADOPTION, ANOTHER ALTERNATIVE"

October 28, 1976
7:00 p.m. - 9:00 p.m.
Kerry Winkelseth
Merle Norman Representative
Louise Lee
Avon District Representative
"MAKE-UP 1976"

November 4, 1976
7:00 p.m. - 8:30 p.m.
Officer Bob Culver
Wichita Falls Police Department
Crime Prevention Unit
"RAPE AND IT'S PREVENTION" Film

November 11, 1976
7:00 p.m. - 8:00 p.m.
Mary Caesar Murphy, Ph.D.
Senior Psychologist
"WOMAN'S ROLE AND IDENTITY"

November 18, 1976
7:00 p.m. - 8:30 p.m.
Bill Parks, Vocational
Adjustment Coordinator
Linda Kristoff, Vocational
Adjustment Coordinator
Caroline Goodwin, Teacher
for the Vocation & Educition
of the Handicapped
Cynthia Prockop
Human Resource Planner
Office of Human Resources
"JOB PROSPECTS -- '76"

Girls Club of Wilmington, North Carolina

A Young Woman's Roots

In February, 1977, "A Young Woman's Roots" began with a pilot program for girls in in grades 5-6 to address the many questions, fears and misconceptions members were expressing about menstruation, childbirth, and their emerging roles as young women. Because no programs were being offered in our community to meet this need, the Girls Club contacted the Health Educator from N.C. Health Region "O" Family Resources, and a program was designed. Each began with participants discussing their own interests and priorities. Outlines were used but emphasis was placed on flexibility for each group to develop at its own pace. A close relationship between this office and Region "O" was necessary for the success and continuation of our program. They provided training for Girls Club staff to help them better understand their own sexuality, become more sensitive to members' needs, and develop skills as listeners and group facilitators.

This was our first attempt to deal with members' needs in the area of human sexuality. Few guidelines existed and our start was exciting as well as a little scary. Because of the enthusiastic response and success of this pilot program, three (3) additional programs were held for girls in grades 5-6 and 7-9 throughout 1977. The only expense to the Girls Club was staff time. All materials were available through Region "O".

With the participation of members, staff and advisors and the information learned from these programs, the Girls Club will implement in 1978 a more comprehensive program of family life/sex education for K-9 grades (see Attachment B) and will be exploring the possibilities of sex education programs for pregnant teenagers and joint programs with local Boys Clubs.

The effects of this program on our club and the community have been positive. Because of the high rate of teenage pregnancy, our area is now becoming more aware of the need for sex education and consequently, is looking to organizations where such programs are being held. A recent series, "Sex and Teenagers", was done on the local evening television news. Our program was discussed since we are one of the few groups addressing this concern in our community. There are no sex education classes in our schools. We are now working with a citizens organization called LIFE (League for Interpersonal and Family Education) to explore ways of instigating programs in the schools and elsewhere. Newspaper articles are appearing regularly and a reporter will be attending a meeting of "A Young Woman's Roots" to find out what this "thing" is which generates so many strong and varied feelings in our community. The Girls Club of Wilmington also presented a workshop at the 1977 Mid-Atlantic Fall Training Conference.

The value to participants is many fold. Educator Curtis Avery has said, "If sex education does no more than dispel sexual ignorance, it is justified in itself." Our program offers information as well as aids in the development of communication and decision-making skills needed to disseminate this information. We strive to created an atmosphere of trust and understanding where one may find out others have similar feelings and discover such feelings are normal and O.K. To search out individual feelings and discover and clarify personal values, is as important as knowing about one's physical self. To like yourself is an important step in liking another human being --- and on and on.

The following is a conclusion written by Region "O" Family Resources; report October 27, 1977.

> "...In the case of the Girls Club sex education program, two staff members identified a need, contacted another agency for program expertise and conducted a pilot project. Before taking over the project as a regular program, the entire staff was sensitized to the issue of adolescent sexuality. Further training and consultation needs will be met by this agency...Members of the Girls Club are now receiving information and values clarification in a consolidated, comprehensive way. "This case illustrates that in an area where the public schools are not meeting the need for a comprehensive living skills program, students involved in extra-curricular programs can be reached by concerned agencies willing to take the initiative."

ATTACHMENT A

1. Objective - Develop an atmosphere of mutual trust.

Action	Resources
- group building exercises	Values in Sexuality, by Morrison and Price Exercises: "The Name Game" "Obstacles to Discussing Sexual Issues" "Getting Acquainted" "Touching" Others: "Introducing Your Partner"
- verbal contract agreement - answer questions honestly - allow opportunity to participate in discussion	

2. Objective - Eliminate fears and misinformation related to sexuality.

Action/	Resources
- information giving	Education for Sexuality, Burt-Meeks Conception, Birth and Contraception Girls and Sex anatomy flip charts
- use audio-visual materials	Films: Human and Animal Beginnings Fertilization and Birth Human Growth It Couldn't Happen To Me Your Breast and Pelvic Examination Filmstrips: Becoming a Woman/ Becoming a Man
- gather information concerning group members' knowledge (what already know/what have retained afterwards)	crosswords, fill in blanks, T/F quizzes

3. Objective - Learn about how our bodies function.

Action	Resources
- information giving (male and female)	(Note: Use same resources as listed in all of Objective #2)
- emphasize menstrual cycle i.e., body changes which signal sexual maturation	Personal Products Booklets: "Growing Up and Liking It" "How Shall I Tell My Daughter"
- explanation of what actually happens during menstruation	

- ask "What will you do when you begin your period?"	
- show variety of sanitary products	Kit of several different sanitary products
- learn to feel comfortable with our own bodies	"Draw a Body" exercise
- body care/hygiene	

4. Objective - Assist in the development of communication skills.

Action	Resources
- offer an opportunity to learn to really listen to what others say	
- develop an atmosphere where members can express themselves freely	
- exercises in "Active Listening - Feed Back"	Parent Effedtiveness Training by Thomas Gordon

5. Objective - Answer all questions asked.

Action	Resources
- generate questions at beginning of class to list and check off as they are answered throughout the discussions	
- offer an opportunity to ask questions which are difficult for them to ask in group, i.e., list on index cards	Question/Suggestion Box
- if group leader does not know answer, record and check out resources before next meeting.	

6. Objective - Assist them in exploring their values and learning how to respect the values and feelings of others.

Action	Resources
- verbal contract agreement: 1) no one puts down another person for what she says 2) you may talk about facts outside of class, but NOT what other people say 3) talk about how you feel - no gossiping about experiences of others	
- discovering many of us have differing values	"Abigail Story" exercise "Sex Role Stereotyping" agree, disagree, neutral

7. Objective - Develop decision-making skills and responsible attitudes

Action	Resources
- group defines "decision"; "what do you need to know before you make a decision?" ask suggestions of a problem and group lists ideas of what you must know before making a decision	
- explore making decisions and then discussing why you made it	"Sex Role Stereotyping" agree, disagree, neutral splits

8. Objective - Learn about the risks and responsibilities of sexual activities

Action	Resources
- discussion of venereal disease	Education for Sexuality
- share facts	
- discussion of Teenage Pregnancies - Risks to Mother and Child	Film: "It Couldn't Happen To Me"
- discussion of birth control	kit of contraceptives
- responsibilities in relationships	
- understanding: -how boys feel -how girls feel - sex drive in both girls and boys	Girls and Sex, Pomeroy
- not using another person	

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ATTACHMENT B

Note: Each group develops its own personality with specific needs and interests. A program must be flexible enough to incorporate these.

"DIVISION OF EDUCATION"

Grades K-3
Objectives #1-#5

Action will be taken from the following areas:
- body parts
- animal families
- human families
- concept of seeds - plants, eggs, etc.

Grades 4-5
Objectives #1-#7

- basic reproduction
- female body development
- menstrual cycle
- responsibility for your own self (nutrition, rest, hygiene)
- family structure

Grade 6
Objectives #1-#8

- reproduction
- body development
- menstrual cycle
- responsibility for your own self (nutrition, rest, hygiene)
- family unit - responsibilities of parenting
- introduction to VD, teenage pregnancy, contraception, values, decision-making
- understanding the different and mutual feelings boys and girls have towards sex

Grades 7-9
Objectives #1-#8

- encourage group "self-direction"
- reproduction
- male and female anatomy and growth
- menstrual cycle
- responsibility for your own self (nutrition, rest, hygiene, breast and pelvic exam)
- family unit - responsibilities of parenting
- VD
- teenage pregnancies - risks to mother and child
- unwanted pregnancies
- contraception
- abortion, sterilization
- values
- decision-making

The CHAIRMAN. That will be helpful. I am sorry I had to be interrupted two or three times during the testimony. I can assure you that all that you said will be carefully read and studied.

If we have further questions, we would like to send them to you, and have you respond for the record, if that would be possible.

Thank you again.

Ms. WURF. Thank you.

The CHAIRMAN. For our last panel we have Dr. George Thoms and Dr. Peter Scales. We welcome you and appreciate you coming here to contribute to our deliberations in search for answers in this area.

STATEMENTS OF PETER SCALES, Ph. D., FOR HIMSELF AND DR. SOL GORDON OF THE INSTITUTE FOR FAMILY RESEARCH AND EDUCATION, SYRACUSE UNIVERSITY, SYRACUSE, N.Y., AND DR. GEORGE H. THOMS, PRINCIPAL, GEORGE MASON HIGH SCHOOL, FALLS CHURCH, VA., ACCOMPANIED BY MS. MARY LEE TATUM, FAMILY LIFE AND SEX EDUCATION TEACHER, A PANEL

Dr. SCALES. My name is Peter Scales. I am representing both myself and Dr. Sol Gordon.

I offer my comments today from a background as a researcher, educator, and counselor who has worked with both young people and parents in sexuality and family life education.

It is ironic that approval of sex education, including the teaching of contraception, has jumped dramatically since 1970—70 percent of Americans believe contraception should be taught in schools, according to Gallup—yet there has not been a corresponding rise in the extent to which States require even the most basic education in human reproduction. In Massachusetts, for example, the State department of education reports that only 15 of the State's 428 school districts offer some formal sex education. A department spokesperson was recently quoted as saying that "there are just too many other important things for educators to worry about today." Perhaps one of those worries should be that, in Massachusetts, the only significant increase in teenage births over the last 2 years has been an 18-percent jump in births to girls under 15.

Most of us would subscribe to the definition devloped by the World Health Organization that sex education programs should be "far more broadly and imaginately conceived" to deal, not only with reproductive physiology, but with "questions of etlrics in interpersonal relationships." The intent of sexuality education is the development of mature persons capable of making wise and responsible decisions.

One of the most important tasks of sex education (as opposed to the mere provision of sex information) is to help young people talk about sex and contraception. We studied 400 college students in upstate New York, and found that one-third said the first time they had sex with someone, it "just seems to happen without talking." This is disastrous, for a recent study by two University of Pennsylvania researchers showed that the ability to discuss contraception before intercourse is significantly related to whether people use contraception. This seems almost absurdly obvious, yet we are doing little to work with this powerful determinent of contraceptive use.

We educators need to acknowledge that many teenagers, and people in their twenties and thirties as well, would like to say "no" more often, not to sex but to potential sexual partners. We can't help some people say "no" to sexual partners, however, if we're telling all young people to say "no" to sex itself. Credible communication means that we meet the needs of those young people who want to have sexual relationships to do so under conditions of forethought, care, and concern.

To accomplish this, we will be teaching about "values." Some forward-looking schools now teach "sex education," but insist they are not teaching values. We, of course, cannot legislate morality, but we also cannot provide effective sex education without helping young people explore what moral behavior means to them. We can't insist that a particular set of values be taught, but we should not then overreact and fail to help young people define what it is they value. I think particularly in this case of some forward-looking schools that do offer sex education curriculum, but explicitly exclude the discussion of birth control. That is a particular value in the very exclusion of the topic itself, while at the same time they are insisting they are not teaching any particular values.

So given that kind of context, I think some recent actions at the Federal level show some great progress.

As mentioned earlier, we need a great deal more data on the effects of sex education.

There has been some progress shown in the recent awarding through CDC of a very large contract to identify the effects of sex education and identify some models of adequate evaluation. In addition, an important but not yet published study detailing several sex and family life education programs has been submitted to the Secretary's Advisory Committee on the Rights and Responsibilities of Women.

As another example, and this is, I think, a particularly good example of linkage among Government organizations and private organizations, the Office of Education, in an advisory capacity, and CDC's Bureau of Health Education, in the funding role, are supporting an ambitious PTA pilot project to establish comprehensive health education programs in six States.

Included with OE on the Advisory Board are the Alan Guttmacher Institute, the Sex Information and Education Council of the United States, the American Council of Pediatrics, and the American Medical Association's Health Education Department. In this project, now in its third year, the PTA, the "lay" group, acts as the fulcrum in the linkage between governmental set-up support and private resource expertise.

In the area of sex and family life training for parents, the National Institute of Mental Health funded a 3-year community-based project of Syracuse University's Institute for Family Research and Education. Over 1,400 parents were participants in sex and family life education courses taught by religious leaders, members of civic organizations, and community education professionals trained in the first phase of the project. In addition, a valuable manual detailing models and providing resources and organizing guidance was produced.

Efforts such as these need continued support. In the St. Louis paper, Planned Births, the Future of the Family, and the Quality of Amer-

ican Life, it was recommended that a two-pronged effort be supported: Continued aid of education for parenthood programs (for instance, OE's 6-year-old project which has involved Boy Scouts, Girls Clubs, 4-H's, YWCA's and others), and increased funding for school-based projects. It was recommended that the Elementary and the Secondary Education Act be amended to provide, as a bare minimum, $20 million for these purposes in fiscal year 1980, to increase to $30 million in fiscal year 1981.

I would amend that recommendation to stress community-linkage projects which include the school as one component, but which are not based solely in the school, and to provide more funds than the minimum, especially for innovative projects involving media and teenagers themselves, such as the "Growing Awareness" project of Rochester, N.Y., Planned Parenthood—funded by DHEW—or the variety of projects undertaken as part of National Family Sex Education Week, another Institute for Family Research and Education project.

If we are to affect the "state of the art" nationwide, however, increases in funding support will not be sufficient; We must more adequately define what should be included in sex and family life education. Government should not dictate to local communities precisely what they should include in a curriculum, yet it can support the development of guidelines. Whether a community substantially reflects those guidelines might be one criterion for its eligibility for community-linkage funds. A first step would be for an appropriate governmental unit, such as OE, to work with groups such as SIECUS, the American Association of Sex Educators, Counselors and Therapists, the American Home Economics Association, the American School Health Association, and others in synthesizing the literally thousands of curriculum plans with which they are familiar. From these, a more uniform set of minimum standards for the "basic skill" of sex and family life decisionmaking can be drafted. These guidelines might then be used, with some modifications perhaps, by States in the regulation of their education.

Perhaps what is needed and what I do not think is present in S. 2910 is the kind of legislative initiative that we had with the educational amendments of 1976, which revised the vocational education laws with regard to sex bias and discrimination. Those amendments charged the Commissioner of Education with developing a vocational education data reporting system and with the task of investigating the extent of sex bias.

It included as a specific purpose the overcoming of sex discrimination, mandated 5-year State plans for accountability, and provided for revising curriculums to remove sex bias.

It seems to me all of these provisions can be readily applied to similar activities in sex education. As I say, this kind of emphasis appears to be missing from S. 2910.

The prevention area seems to have been given short shrift. There seems to be little recognition of some of the explicit components of what I mentioned earlier, what might be effectively included in prevention.

The bill has several good points, one of which I have not heard anyone mention today, which I would like to emphasize in that it calls for the involvement of teenagers themselves in the planning and conduct of any funded projects. I really would like to stress that.

I think we need more teenager involvement. Too many times well-meaning community leaders prepare programs that they think are going to meet the needs of teenagers and they actually do not.

But whatever the bill's merits, it has an inherent structural flaw, and that is it seems to me the bill is trying to do too much under one authorization. Everything from preventing pregnancies to caring for pregnant teenagers, to a rather amorphous goal of "helping adolescents become productive independent contributors to family and community life."

I would like to mention a couple steps very quickly that I think would improve the bill:

One, prevention should be clearly separated from postpregnancy management, both in concept and funding.

Two, there should be explicit encouragement of communication-based sex and family life education that deals with relationships and decisionmaking.

And, three, more funds should be under the Secretary's discretion for evaluation, perhaps 3 to 5 percent of the appropriations rather than the proposed 1 percent.

Fourth, funds should be available for abortion.

And, five, total funds need to be increased, figures and numbers are included——

The CHAIRMAN. You did say funds should be available for abortion?

Dr. SCALES. Yes. There should be a recognition, and perhaps this bill is not particularly the appropriate place, but there should be a recognition that society in many ways fails to enable young people who wish to avoid a pregnancy to avoid that pregnancy. There is little recognition in the language of the bill that society has a responsibility to help those people whom it has failed through the sexual health care system to avoid a pregnancy, to resolve that pregnancy in a manner that is effective for them. At the least, counseling and referral should be included in any preventive effort.

In conclusion, it is obvious now we are ready to acknowledge that education while it cannot solve all of the problems can be a tool which young people tend to use in their own best interests.

We have the responsibility to provide not just information, but insights into sex roles, intimacy, communication, and the meaning of parenthood.

Most parents and community groups are allied in this process. Government has stepped up its visible involvement.

We no longer need be left only with watered-down courses in the "plumbing" of sexuality.

We can make it easier for teenagers to have enjoyable and responsible sexual lives, but only if we confront the issues long enough to see sex from their perspective and have both the vision and the courage to try something new.

Thank you.

The CHAIRMAN. Dr. Scales, you have a document you have been referring to. Could we have the full statement?

Dr. SCALES. You have copies of it.

The CHAIRMAN. That is part of our record and will be. Excellent.

[The prepared statement of Dr. Scales follows:]

misc on P. 125

SEX EDUCATION AND THE ROLE OF THE FEDERAL GOVERNMENT

by

Peter Scales, Ph.D.*

Testimony submitted to the Senate Human Resources Committee

July 12, 1978

*Peter Scales has been Research Director at the Institute for Family Research and Education, a consultant with the Family Impact Seminar at George Washington University, and Teen Project Director at the National Organization for Non-Parents. He is co-author (with Sol Gordon and Kathleen Everly) of The Sexual Adolescent: Communication Strategies for Professionals, to be published this fall by Duxbury.

SEX EDUCATION AND THE ROLE OF THE FEDERAL GOVERNMENT by Peter Scales, Ph.D.

Testimony submitted to the Senate Human Resources Committee, July 12, 1978

My name is Peter Scales. I offer my comments today from a background as a researcher, educator and counselor who has worked with both young people and parents in sexuality and family life education.

Context of Sex Education

Educators and policy-makers can no longer ignore the clear social trends. The pattern today is for young people to have their first intercourse earlier than in previous generations, and for a greater percentage of young people to be sexually experienced at all ages. Twenty percent of teens under 15 have had intercourse, and each year one in ten teenage women becomes pregnant.

It is ironic that approval of sex education, including the teaching of contraception, has jumped dramatically since 1970--70 percent of Americans believe contraception should be taught in schools, according to Gallup--yet there has not been a corresponding rise in the extent to which states require even the most basic education in human reproduction. In Massachusetts, for example, the State Department of Education reports that only 15 of the state's 428 school districts offer some formal sex education. A department spokesperson was recently quoted as saying that "there are just too many other important things for educators to worry about today." Perhaps one of those worries should be that, in Massachusetts, the only significant increase in teenage births over the last two years has been an 18 percent jump in births to girls under 15.

We can trace this lack of initiative in the schools back to the controversy in the late sixties, when the battle-cry of extremists was that sex education caused promiscuity and unwanted pregnancies. Of course, research shows this to be untrue, but for years we have allowed this charge to define what we mean by sex education, and thus have assumed largely a defensive posture.

Most of us would subscribe to the definition developed by the World Health Organization that sex education programs should be "far more broadly and

imaginately conceived" to deal, not only with reproductive physiology, but with "questions of ethics in interpersonal relationships." The intent of sexuality education is the development of mature persons capable of making wise and responsible decisions.

One of the most important tasks of sex education (as opposed to the mere provision of sex information) is to help young people talk about sex and contraception. We studied 400 college students in upstate New York, and found that one-third said the first time they had sex with someone, it "just seems to happen without talking." This is disastrous, for a recent study by two University of Pennsylvania researchers showed that the ability to discuss contraception before intercourse is significantly related to whether people use contraception. This seems almost absurdly obvious, yet we are doing little to work with this powerful determinent of contraceptive use.

We educators need to acknowledge that many teenagers, and people in their 20s and 30s as well, would like to say "no" more often, not to sex but to potential sexual partners. We can't help some people say "no" to sexual partners, however, if we're telling all young people to say "no" to sex itself. Credible communication means that we meet the needs of those young people who want to have sexual relationships do so under conditions of forethought, care and concern.

To accomplish this, we will be teaching about "values." Some forward-looking schools now teach "sex education," but insist they are not teaching values. We of course cannot legislate morality, but we also cannot provide effective sex education without helping young people explore what moral behavior means to them. We can't insist that a particular set of values be taught, but we should not then over-react and fail to help young people define what it is they value.

The best education of this sort attempts to place sex education in a total framework meant to help young people understand all aspects of the human growth process. In Flint, Michigan, for example, sex education is an important

facet of all family life education, and human reproduction is just one part of sex education. Their program provides opportunities for students to explore, test and retest attitudes and opinions with teachers and fellow students. In another example, sex education in the Baltimore public schools is included in a Survival Skills package within the health curriculum.

Suggestions for Government Action

There are a number of positive contributions which government can make to effective sex education. In general, these are in the areas of legislative and programmatic establishment of sexuality and family life education as priorities, curriculum and resource guidance, and provision of support to a wide variety of community groups engaged in developing local programs to meet local needs.

Although Secretary Califano announced a year ago his support for sex education, and although some innovative programs have been funded by various federal agencies, there is a pervasive, sometimes subtle neglect of sex and family life education in many governmental programs. For instance, the National Longitudinal Study of the high school class of 1972, a study of 22,000 young people, contained not a single question on their experiences with sex education and their impressions of its value in their lives. The 1976 National Panel on High School and Adolescent Education talked only vaguely of the school's responsibility to prepare youth for "future family roles." And it is only in the last year that National Assessment of Educational Progress has begun to consider including some venereal disease knowledge questions in its tests of basic skills.

Yet, some recent actions show progress and should serve as models for future governmental involvement. A good sign is the recent awarding, through the Center for Disease Control, of a large contract to identify the effects of sex education and models of adequate evaluation. In addition, an important, not yet published study detailing several successful sex and family life education

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programs has been submitted to the Health Subcommittee of the Secretary's Advisory Committee on the Rights and Responsibilities of Women. Also, a recent RFP issued through the Health Services Administration (HSA240-BCHS-167(8)DLP) is concerned with the development and testing of educational materials for use by parents in providing guidance in family planning and sexual decision-making.

In another example, the Office of Education, in an advisory capacity, and CDC's Bureau of Health Education, in the funding role, are supporting an ambitious PTA pilot project to establish comprehensive health education programs in six states (Arkansas, California, Colorado, Georgia, Indiana and Pennsylvania). This involvement also illustrates federal and private cooperation: Included with OE on the advisory board are the Alan Guttmacher Institute, the Sex Information and Education Council of the U.S., the American Council of Pediatrics, and the American Medical Association's Health Education Department. In this project, now in its third year, the PTA, the "lay" group, acts as the fulcrum in the linkage between governmental set-up support and private resource expertise.

In the area of sex and family life training for parents, the National Institute of Mental Health funded a three-year community-based project of Syracuse University's Institute for Family Research and Education. Over 1400 parents were participants in sex and family life education course taught by religious leaders, members of civic organizations, and community education professionals trained in the first phase of the project. In addition, a valuable manual detailing models and providing resources and organizing guidance was produced.

Efforts such as these need continued support. In the St. Louis Paper, Planned Births, the Future of the Family, and the Quality of American Life, it was recommended that a two-pronged effort be supported: Continued aid of education for parenthood programs (for instance, OE's six year old project which has involved Boy Scouts, Girls Clubs, 4-H's, YWCA's and others), and increased funding for school-based projects. It was recommended that the Elementary and

and Secondary Education Act be amended to provide, as a bare minimum, $20 million for these purposes in FY 1980, to increase to $30 million in FY 1981.

I would amend that recommendation to stress community-linkage projects which include the school as one component, but which are not based solely in the school, and to provide more funds than the minimum, especially for innovative projects involving media and teenagers themselves, such as the "Growing Awareness" project of Rochester (NY) Planned Parenthood (funded by DHEW) or the variety of projects undertaken as part of National Family Sex Education Week, another Institute for Family Research and Education project (see attached).

If we are to affect the "state of the art" nationwide, however, increases in funding support will not be sufficient: We must more adequately define what should be included in sex and family life education. Government should not dictate to local communities precisely what they should include in a curriculum, yet it can support the development of guidelines. Whether a community substantially reflects those guidelines might be one criterion for its eligibility for community-linkage funds. A first step would be for an appropriate governmental unit, such as OE, to work with groups such as SIECUS, the American Association of Sex Educators, Counselors and Therapists, the American Home Economics Association, the American School Health Association and others in synthesizing the literally thousands of curriculum plans with which they are familiar. From these, a more uniform set of minimum standards for the "basic skill" of sex and family life decision-making can be drafted. These guidelines might then be used, with some modifications perhaps, by states in the regulation of their education. The NEA project is a good example of this kind of activity, although they are only now, after three years of building support and defining common interests, beginning to develop a curriculum.

Government cannot be value-free in this task. While specific content and particular resources should be under the discretion of local and state authorities, the federal role must be to hold good for the free flow of ideas

and information. Schools that try to teach sex education, while, as a gesture to a vocal minority expressly forbid the teaching of birth control, are not the allies of society. Institutionalizing ignorance in this manner may temporarily solve the issue of local politics, but its long-range impact is to create more public health problems and more need for costly remediation--as the Planned Births paper pointed out, every dollar invested in family planning services saves nearly two dollars in welfare-type costs. Effective sex education should ensure that those dollars are even more efficiently spent.

Perhasp what is needed is a legislative initiative similar to the Educational Amendments of 1976, which revised vocational education laws in regard to sex bias and discrimination. Those amendments charged the Commissioner of Education with developing a vocational education data reporting system, and with the task of investigating the extent of sex bias. It included as an explicit purpose the overcoming of sex discrimination, mandated five year state plans for accountability, and provided for revising curricula to remove sex bias. All these provisions can be readily applied to similar activities in the area of sex and family life education.

It is this kind of emphasis that appears to be missing from S 2910. The bill seems more oriented to post-pregnancy management than to primary prevention, and of course it is in primary prevention that sex and family life education can make their greatest impact. The bill has several good points. The mere fact of developing an initiative on teenage pregnancy has helped raise the visability of the problem and of attempts to control it. Especially important, the bill calls for involving teenagers and their families in the planning and conduct of funded projects, and recognizes the importance of outreach.

But whatever the bill's merits, it has an inherent structural flaw: Too much has been mandated under one authorization, everything from pregnancy prevention, to care for pregnant teens, to helping "adolescents become productive independent contributors to family and community life." It seems that a greater service could be done both teenagers and society's resources by allowing

the primary prevention effort its own arena and funds. Here are some steps that could greatly strenghten the bill:

*prevention should be clearly separated from post-pregnancy management, both in concept and funding.
*there should be explicit encouragement of communication-based sex and family life education that deals with relationships and decision-making.
*more funds should be under the Secretary's discretion for evaluation, perhaps 3-5 percent of the appropriations rather than the proposed one percent.
*funds need to be increased. By contrast to 2910's total outlay of $60 million for education and services, the PHS Title X extention proposed $35 million, just for services to reach only one-third of the remaining two million teenage women at risk of unintended pregnancy.

In conclusion, it is now obvious that we are witnessing the arrival of teenage pregnancy as a social cause. We are ready to acknowledge that education, while it cannot solve all of the problem, can be a tool which young people will tend to use in their own best interests. We have a responsibility to provide, not just information, but insights into sex roles, intimacy, communication, and the meaning of parenthood. Most parents and community groups are now allies in this process, and government has stepped up its visible involvement. We are no longer left only with watered-down courses in the "plumbing" of sexuality. We can make it easier for teenagers to have enjoyable and responsible sexual lives, but only if we confront the issues long enough to see sex from their perspective and have both the vision and the courage to try something new.

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NATIONAL FAMILY SEX EDUCATION WEEK REVIEW - 1977

As a result of much effort, National Family Sex Education Week - 1977 was the best ever. An indicator of its growing significance and impact, 8 state governors issued official proclamations urging all civic, medical, educational, voluntary and health care professions and organizations to commemorate the week and the weeks and years to come by efforts to educate and assist the public. Among the states to issue proclmatations were: Alabama, Michigan, New Jersey, Pennsylvania, Oregon, Hawaii, New Mexico, and Delaware. Dozens of major cities and counties issued similar proclamations: San Francisco, Miami, Dade County, Sacramento, the California legislature, the Detroit City Council and the City of Detroit, among others.

The Family Planning Council of Western Massachusetts organized programs throughout its encompassing counties. Talk shows, interview shows, news spots, call in shows were organized for TV and radio. There were articles for newspapers, poster displays in area libraries, and community lectures on "Sex Education and the Role of the Parents."

Planned Parenthood League of Detroit received a great deal of feedback as a result of their media campaign, which generated calls for more information from interested individuals and groups who read newspaper articles, heard radio broadcasts and/or saw television shows. The response from the community was very positive, and prompted many requests for literature and speakers. According to Jennifer Kundak, education director, "Overall, we were pleased with the enthusiastic level of support from the media, who voiced appreciation for all the information and resources we shared with them. Many former media contacts were strengthened and new ones solidly formed through our activities, which we hope to continue to build upon in the future."

The Department of Health and Social Services in Anchorage, Alaska was very active in working on National Family Sex Education Week. They distributed approximately 5,000 flyers to churches as bulletin inserts, bookstores, colleges, health centers and hospitals. The flyer included a statement of purpose, listing of endorsing organizations, further information phone numbers, and a calendar of events to look for on television and in the community, and finally a suggested reading list.

A "Family Sex Education Fair" was held in the Holyoke Hospital Auditorium, Massachusetts. The Fair was an attempt to present information to parents in a unique and exciting way. It consisted of booths set up in the auditorium where parents and interested adults could pick up different types of information and materials related to sex education. The Fair included booths on venereal disease, reproductive anatomy and physiology, sex education for young children, sex education and the mentally retarded, sex education in the schools, teen sexuality, communicating about sex with your child, birth control, and religious views on sex education. Seventeen resource people were available to discuss questions and concerns parents have. There were also periodic showings of several sex education films with open discussions held after each film. Because of the great response from the hundreds of people that attended, plans have already begun to make 1978 Family Sex Education Fair bigger and better.

Along with talk shows and newspaper coverage, the Center for Human Concern in St. Louis, Missouri coordinated a one-day institute at a local high school entitled "The Family, the Teenager, and Sexuality." Through the efforts of Martha Browder, a sex education classroom teacher, sex educators, school admini-

atrators, teachers, students and parents participated in an exciting and informative day. Among the topics discussed were "Sex Role Conflict of the Young Man," "Special Concerns of Young Women," "Teenage Pregnancy," "Teens and the Media" and "The Black Teenager and Sexuality."

A very active group is the Statewide Family Planning Project of Alabama. Family Sex Education Week as declared by a proclamation by Gov. George C. Wallace, was spearheaded by Sue Campbell, State Sexual Training Coordinator. One of the many programs and services it provided was an administrator's workshop hosted by the renowned sexologist and author, Dr. Takey Crist.

A colorful flyer was sent to all area junior and senior high schools as well as service agencies by the Reproductive Health Care Center of South Central Michigan. This flyer outlined excellent supplemental material for classes that was being broadcasted on TV during NFSEW. Such topics as sex education in the schools, how to tell your children about sex, teen pregnancy, and open lines to call in questions were among the many discussed on daily television programs. Also provided was sex education material at public libraries and on all displays.

Angie Brown, Program Director, Kirkwood Community College, Iowa organized a series of evening lectures. Just a few of the extremely interesting topics were: "Sexuality Problems Faced By Single Parents," "Sexuality and the Handicapped," "Effective Methods of Birth Control," and the "Family Role in Sex Education."

The newly developed Sex Health Education Center of Florida has again provided the Dade County area with excellent opportunities in growth promoting and responsible sex education. Under the direction of Lynn Leight, RN, the organization benefitted from past successes with additional innovative seminars, workshops and poster contests, designed to invited greater parent/teen involvement. This year's efforts had considerable political support.

One of the major events promoted was a "Sex Symposium" which had an attendance of over 800 teens. The response was so enthusiastic that 97% of those who attended requested that NFSEW be celebrated more frequently. Workshops were offered which included parent-child communication, teenage pregnancy, birth control, culture differences in sex, love and marriage, sexual self pride, VD, homosexuality, among others.

The official endorsement from six mayors in Dade County, presenting validating proclmations, added great credibility to the event. The media was tremendously supportive with every newspaper covering the week's activities. The Miami Herald devoted its Sunday supplement to "What Happens When Children Have Children." The Miami News ran a four-part investigative series on "Sex and Teenagers." The News also ran an opinion poll in which 72% of the readers responded in favor of sex education in their schools.

The radio and TV coverage was equally responsive. WKAT radio's opinion poll revealed that 76% of the callers were in favor of a mandated school curriculum. Saturday night "Montage" and "Good Morning Miami," along with a Sunday night's "Point-Counterpoint" explored the need for sex education and endorsed the efforts to raise the consciousness of the community through National Family Sex Education Week.

Among many of the activities sponsored by the Northern Michigan Planned Parenthood were: radio spots, proclamation by the city mayor declaring October, Sex Education Month, tv talk shows, newspaper coverage, bookstore displays, posters in store windows, letters to local service groups, publication of a bibliography

aimed at young children and their parents, and a four-session seminar for parents of young children was presented at College Day.

The City-County Health Department of Eau Claire, Wisconsin wrote a letter to the regional public television station asking if they might be interested in celebrating National Family Sex Education Week. They received a response asking that the department form an area-wide committee, including a cross-section of the helping professions as the television company was willing to produce a ½ hr. program on the subject. After considerable planning, a videotape on the theme, "Family Sex Education: Are You an Askable Parent?" was presented twice during NFSEW. The tape includes discussions of sex education questions and problems between youth, parents, and professionals.

Planned Parenthood of Waterbury, Conn. introduced its community to "Sigmund the Stork." The giant feathered bird stood proudly in the lobby of the Waterbury Library along with a selection of resource material for young people and parents on sex education, as well as copies of the handbook, "Sex Education at Home," distributed free. "Sigmund the Stork" then moved on for a visit at the YWCA, accompanied with the poster explaining his presence and reminding parents of their responsibility in giving accurate information, not perpetuating myths. The local newspaper carried a picture story of "Sigmund" and the community college co-sponsored an educational seminar on "Being Askable."

The Hartford Planned Parenthood organization was able to get three local TV channels to do special programming in human sexuality. Special emphasis was given to the parents' roles in this educational process.

National Family Sex Education Week was spearheaded by the Aspen Sexuality Task Force by having several local programs geared around sex education and information in the community. Among the local activities was a one-hour TV discussion called "Grass-Roots" which followed a special "All in the Family," presentation on CBS in which Edith Bunker faces the realization of rape. The task force also sponsored spot announcements on local radio stations and the show "Talk Back" was devoted to sexuality subjects during the week.

Planned Parenthood of Delaware and Otsego Counties, New York placed posters explaining NFSEW in libraries and churches in the two counties. A series of public service announcements were aired on all the local AM and FM stations. A three part series on sex education was on the family page in the local newspaper. The organization had an all-day workshop for outreach and community workers from other agencies on "Outreach and Sex Education." Planned Parenthood also participated in a health fair at a local shopping mall. A table was prepared with signs explaining NFSEW; free bibliographies and booklets on sex education were made available.

As a culmination to the Week, the New York Medical College's Family Life Theatre performed, "Inside-Out - A View of Teenage Life." The theatre is made up of teens who present a play based on the problems of teenage life.

Planning for a Portland Metropolitan area Oregon Family Sex Education Week began in May 1977 when a meeting in Portland of people from around the state assigned organizational and individual responsibilities. The statewide group assumed responsibility for developing a resource guide, developing television public service announcements, and soliciting endorsements from statewide organizations and public officials. Over 40 public officials and organizations endorsed the week, including Governor Straub of Oregon. Among the many activities was a comprehensive media coverage, using television public service announcements, radio public service announcements, newspaper and newsletter coverage. The Oregon group set up a state-wide toll free telephone information line which was installed at Planned Parenthood and answered by the staff of the Education Department. A speaker's bureau was set up to provide resources to groups and organizations. Eight thousand "Are You An Askable Parent?" flyers were printed by the Mt. Hood Council of Camp Fire and distributed to youth, church, service groups, and interested individuals. One of many highlights was the participation of Dr. Mary S. Calderone, President of SIECUS, who graciously appeared on TV and gave several lectures.

A major project of the Hawaii Planned Parenthood entailed a comprehensive bibliography of up-to-date literature (books/booklets) designed to aid parents in assuming a primary role in the sex education of their children. The list was broken down into age categories and includes materials for special populations including the retarded, disabled, aged, and others. In response to a request from Hawaii Planned Parenthood and the Department of Health, the Governor of Hawaii issued a proclamation in support of NFSEW.

Observance of NFSEW in Missoula, Montana was initiated through a proclamation signed by Mayor Bill Gregg. Several special activities were planned, one of which was an "Askable Parent Workshop" to assist parents of children through the sixth grade to the sex education of their children.

Some other West Coast efforts concentrated in California. The cities of Sacramento, Los Angeles, San Mateo, Marin, Fresno, and Santa Barbara, were among the many that put forth great energy into NFSEW. Major emphasis was placed on reaching the media, with secondary emphasis placed on developing a strategy to motivate Health departments, Planned Parenthoods, Family Service Agencies and others to get many groups interested and have them reach out to their memberships and to the public to promote awareness of NFSEW. Library displays and special reference book lists were used in a number of agencies. Several Planned Parenthood agencies in California conducted parent education courses in conjunction with NFSEW. Other promotional efforts included: sending letters to the headquarters of statewide agencies in California asking for endorsement of the Week; packets of tips, public relationship ideas, public service announcements, and newsletter samples were sent to endorsing agencies over the West Coast; a special letter was sent to Family Service agencies with a newsletter of activities and sample articles; copies of Mayor Moscone's (San Francisco) proclamation with an accompanying news release went to newspapers, television, and radio stations in the San Francisco Bay area; information packets were sent to a selected list of 100 Bay Area Churches resulting in requests for inserts for their church bulletins.

Political endorsements in California came from the State Legislature, the Secretary of State, Mayors of a number of cities, and several city councils. In Sacramento, a large and successful press conference was held on the steps of the state capital to mark the start of the week on October 3. The entire capital press corps turned out and the event was also well covered by television and radio.

Public service radio announcements were sent to stations all over the West Coast. In the Bay area there were 7 radio talk shows. Television coverage included repeats of the TV special, "Guess Who's Pregnant" in San Francisco, Los Angeles, and Sacramento. San Francisco TV Channel [illegible] an 5-part series called "Unwanted Children" [illegible] time viewing.

The CHAIRMAN. I will not get into your suggestion on making funds, through this program, available for abortion. I will just tell you that the practical legislative life will say no. The program would have embedded its own death with that in this program. There are other ways that I personally—and this is only personally I am speaking now—would hope that the full range of needs could be supported and met. But as you say, you feel this bill perhaps is too amorphous and suggests too many areas in one legislative place. You did say that?

Dr. SCALES. That is right.

The CHAIRMAN. This would be another that would be beyond the reach of this particular effort here in my judgment. While I do not want to discourage thinking about the full range of needs, we are going to have to be careful to be rather precise about that which we intend to accomplish in terms of national resources.

Dr. Thoms.

Dr. THOMS. Senator Williams, thank you for this opportunity.

Dr. Cody Wilson, Executive Director of the 1972 Presidential Committee on Obscenity and Pornography recently revealed research telling that 8¼ million instances of sexual intercourse by 2 million adolescents are occurring each month. This adolescent sexual behavior is resulting in large numbers of teenage pregnancy, sexually transmitted diseases, teenage marriages and divorces, school dropouts, and great consternation among parents and members of the society at large. As high school principal and high school teacher, we are here today in support of the proposed "Adolescent Health Services and Pregnancy Prevention and Care Act of 1978."

Because of the increasing concern about adolescent health services, during this past year, by invitation, we have traveled to consult with interested school and community groups in Mississippi, California, Massachusetts, Texas, as well as the metropolitan Washington area (Maryland and Virginia). In addition, we have responded to hundreds of written requests for information.

Our traveling and our responding supports and reinforces our contention that supporters of education about human sexuality are ready to decide and act on programs which will provide information and services for teengers across this country. People are searching for information and successful programs which they can use as a foundation for action in their own communities.

As principal and teacher at George Mason Junior-Senior High School in Falls Church, Va., it has been our professional privilege to be directly involved in a unique instructional program about human sexuality implemented in grades 8, 9, 11, and 12. Our experience has been as developers and implementators of the program for the past 7 years (since 1971). We are convinced not only that education about human sexuality has as important a place in the school as reading, writing, and arithmetic, and that it is in fact just as "basic," but also that it can happen without turmoil and great emotion.

Carefully planned programs about human sexuality with representative and widespread community involvement and attention, taught by staff members acceptable to the community, can as we have experienced, "help adolescents become productive independent con-

tributors to family and community life." We agree with those who argue that school cannot be and should not replace the personal relationship between parent and child or usurp the role of religious institutions.

The schools, however, are the only institutions that reach practically all of our children and for a substantial period of time. The schools are organized and prepared to work with all the children, both the hard to reach and easy to reach, the churched and the unchurched, and those who have confiding relationships with their parents as well as those who do not.

Ms. TATUM. I hope by now that despite earlier expressions that sex education in the schools is not doing the job or not comprehensive enough is something we take strong exception to. As a matter of fact, comprehensive programs in sex education are very difficult to find in public schools and we really feel they have not been tried. Not only that, but evaluation of these programs is very difficult to come by. Nevertheless, there is a large body of literature that would show for those of us who work on day-to-day basis with teenagers and their parents that there is tremendous support and appreciation for those public institutions which do attempt to deal with their young people on that comprehensive basis.

Just a couple of examples. Parents who say that for the first time in their family lives their values have been discussed easily around the dinner table or at home in the evening when a child would bring up the topic of abortion, homosexuality, or contraception very easily because it is discussed in the classroom during the day. On the part of teenagers themselves, a very common evaluation in senior seminar given often by boys is that for the first time they have heard their peers talk seriously about the subject of sexuality that was not a jab in the ribs, a dirty joke, a lot of who scored last night, and a lot of dishonest talk. For them sex would never be that kind of discussion again.

Our feedback from these parents and students keeps us convinced not in a statistically viable way, but in a very personal and intense way, convinced that a program which deals with confronting young people with their family values, what they are, and with discussion of their own sexuality in their relationships is essential.

Dr. THOMAS. Senator Williams, we would like to make the following recommendations in support of the bill to be used during its implementation.

First, that the Federal Government publicly acknowledge and support research findings, and indicate its concern, about the large number of teenage abortions, full-term pregnancies, the great incidence of sexually transmitted diseases, and related health and social problems.

Second, through the Office of Education, provide trained, knowledgeable personnel to assist State and local educational agencies and communities in the exploration and development of education about human sexuality.

Three, provide funds to schools and communities willing to investigate the organization and development of education about human sexuality appropriate to their local and peculiar needs.

Four, acknowledge and/or establish model family life and sex education programs to assist those attempting to establish their own programs.

Finally, whether or not our young people should be involved in education about human sexuality is not the issue, but rather what kind and how much. We are convinced that with the support of the Federal Government through the proposed Senate bill 2910, local communities and educational agencies can be assisted and served as they develop and implement that which is appropriate to their own special needs.

Thank you.

The CHAIRMAN. Thank you very much. I just wonder now, I think the generalizations that were made that there has not been conspicuous success across the country of sex education, is a generalization that can be made—is that the way you look at it?

Ms. TATUM. Yes; I would look at it that way.

The CHAIRMAN. Your experience suggest that this is not a necessity, that with certain approaches you can reach people of student age?

Ms. TATUM. I think Falls Church is a very conservative kind of community.

The CHAIRMAN. I was wondering if there is any way of making a case study of how the problem areas were met in Falls Church. If it is anything like any community I am familiar with, you have an elected school board, and those boards that I know—this is an area that is a big obstacle in their minds. That is where the controversy begins, the school board, and then from the board to the community, and even with great enlightenment within the schools and within some of the instructors, the teachers there, you run into community problems of some dimension.

Did you have any in your school district—did you have a lot of patience to reach the board with the wisdom of what you were doing or wanted to do?

Dr. THOMS. Senator Williams, we have attached several pages which describe exactly how we think the program should be established and should be done and organized. It took us a full year to establish the beginning of our program, and during that full year we worked with our local clergy, our medical people, our school board people, our PTA people, and we worked together with them at developing what we felt would be appropriate for our special needs. The school did not impose anything. The school did not impose anything on the community. The community and the school worked together in deciding what would be appropriate.

We spent a whole year talking about penises and vaginas and masturbation and abortion, and deciding with our Catholic priest and our Protestant minister what would be OK and what would not be OK to talk about in classrooms.

As it ended up, we have a pretty broad program that includes all major areas such as masturbation, homosexuality, contraception, and abortion.

Our community stays in touch with us regularly through our aggressive efforts, meeting with them twice a year to discuss what we are presently doing and asking for their approval.

Ms. TATUM. There is a great deal of emphasis on continued relationship with the community. Our continued emphasis is on relationship with the community. There has to be something of a trust level established between the community and the schools.

The CHAIRMAN. How far back does this go in preparation for teaching at the elementary, secondary level of education? Do the universities include this as part of their curriculum for prospective teachers?

Dr. THOMS. I think it is our feeling that that is a weak area, that there is not an awful lot of training available for teachers at the university level. The American Association of Sex Educators, Counselors and Therapists provides training, and there are other organizations that provide training.

We are not convinced that the university is really doing the job. It is kind of a chicken-and-egg problem. The universities are not doing the job because there are no places to send the people who would then be trained because there are so few sex education programs.

We are convinced though that the teacher is critical to the program, and we are also convinced that the community needs to be part of deciding who that teacher will be. We are not convinced at all, and are very much opposed to communities or schools deciding that in health education departments or physical education departments, all of those teachers should be sex educators or all English departments should be sex educators. We are convinced that special people should be used in sex education because of its sensitivity.

We are more convinced that it is the teacher critical to the program rather than the area of school program.

We think sex education could just as well be taught in social studies or health or home economics or science, as anywhere. It is to us most important that the teachers be selected and then the programs be put where those teachers are.

The CHAIRMAN. I understand you.

Do you think it would be wasteful of our time to think in terms of something that is not very well accepted any more around here? That is, a categorization in one of our education bills, that would provide some money for the training of teachers?

Dr. THOMAS. We would see that as being part of this, Senator Williams. Our suggestion is that the Office of Education provide personnel trained to assist those.

Dr. SCALES. I would like to point out, Senator Williams, that the Alan Guttmacher Institute and others did recommend in a major paper on planned births and the future of the family, that the Elementary and Secondary Education Acts be the focus of some $20 million in fiscal 1980 for just this kind of purpose, for training teachers and for sponsoring projects like this.

Ms. TATUM. I would like to say I think it is very important that the community trusts that they are going to be a part of that process which say what their children are going to be exposed to, that it is not a program of people who come down from somewhere who consider themselves as experts.

The CHAIRMAN. I am going to have to make copies of this [indicating]. This is going to be my copy to carry with me.

Thank you. It seems to me that in the area of prevention and education, we really are still in search of some defined effort to discover the best manner in which to proceed. We do, however, have some effective answers as to the "how" and "why" supportive services work. It has been demonstrated that if you have the resources, you are going to apply answers. As was noted by one of our witnesses today, Ms. Meg Rini, this newspaper clipping illustrates that "Teen Pregnancies are on the Rise in Jersey"—the State that I come from. I would say that the failure of education has certainly contributed to the increasing incidence of this problem, and much still needs to be done.

We could go on an on. It would be very valuable, but the time is limited.

At this point, I order printed all statements of those who could not attend, and other pertinent material submitted for the record.

[The joint prepared statement of Dr. Thoms and Ms. Tatum, and material referred to, follow:]

TESTIMONY PRESENTED TO U.S. SENATE COMMITTEE ON
HUMAN RESOURCES BY DR. GEORGE H. THOMAS & MS. MARYLEE TATUM
OF THE FALLS CHURCH CITY PUBLIC SCHOOLS
FALLS CHURCH, VIRGINIA
JULY 13, 1978

Dr. Cody Wilson, Executive Director of the 1972 Presidential Committee on Obscenity and Pornography recently revealed research telling that eight and one-quarter million instances of sexual intercourse by two million adolescents are occurring each month. This adolescent sexual behavior is resulting in large numbers of teenage pregnancy, sexually transmitted diseases, teenage marriages and divorces, school dropouts, and great consternation among parents and members of the society at large. As high school principal and high school teacher, we are here today in support of the proposed "Adolescent Health, Services, & Pregnancy Prevention & Care Act of 1978".

Because of the increasing concern about adolescent health services, during this past year, by invitation, we have traveled to consult with interested school and community groups in Mississippi, California, Massachusetts, Texas, as well as the metropolitan Washington area (Maryland & Virginia). In addition, we have responded to hundreds of written requests for information. Our traveling and our responding supports and reinforces our contention that supporters of education about human sexuality are ready to decide and act on programs which will provide information and services for teenagers across this country. People are searching for information and successful programs which they can use as a foundation for action in their own communities. As principal and teacher at George Mason Junior-Senior High School in Falls Church, Virginia, it has been our professional privilege to be directly involved in a unique instructional program about human sexuality implemented in grades 8, 9, 11, & 12. Our experience has been as developers and implementators of the program for the past seven years (since 1971). We are convinced not only that

education about human sexuality has as important a place in the school as reading, writing, and arithmetic, and that it is in fact just as "basic,"but also that it can happen without turmoil and great emotion. Carefully planned programs (See attachment) about human sexuality with representative and wide spread community involvement and attention, taught by staff members acceptable to the community can as we have experienced "help adolescents become productive independent contributors to family and community life". We agree with those who argue that school cannot and should not replace the personal relationship between parent & child or usurp the role of religious institutions. The schools however are the only institutions that reach practically all of our children and for a substantial period of time. The schools are organized and prepared to work with all the children, both the hard to reach and easy to reach, the churched and the unchurched, and those who have confiding relationships with their parents as well as those who do not.

Comprehensive programs of education for sexuality in public school settings are few, and statistical evolution of their effects are almost non-existent. However in day to day interaction with several hundred students and parents in the past seven years, there are several repeatedly voiced themes which lend support to a need for the encouragement of such programs.

Parents have said, "we've had opportunities to discuss our values with our children concerning issues like abortion, contraception and homosexuality because they bring up the topics naturally as a result of the classroom discussion.

Or from students: "I've heard my friends in this class discussing sex seriously for the first time. Always before it has been a jab in the ribs, a dirty joke, who "scored" last night, lots of

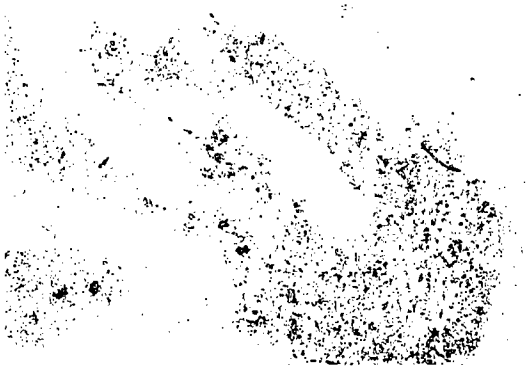
dishonest talk. The discussion of sex will never be that way for me again."

Our feedback from parents and students has convinced us that in addition to having acquired basic and accurate information about physical structure and sexual function, that student behavior changes have included more caring attitudes, and more confidences in themselves in making decisions about their own behavior.

Sexuality is so much at the root of human identity and sex education does take place in all of our lives all of the time. It is put forth by our entire cultural matrix as a confusing contradicting mass of mythology increasing adolescent anxiety about their bodies' development and function, thus leading to decisions made on the basis of peer pressure and ignorance. It is our hope that significant institutions and adults show teenagers that they value giving them good information and a setting where they can consider positive relationships and viable goals for their lives.

As a result of our very positive experiences with our instructional program in human sexuality and as a result of our consultation and deliberation with school and community people around the country during the last year, we respectfully urge and recommend not only the passage of the Kennedy, Williams, Javits-Hathaway Senate Bill 2910, but we also specifically propose the following action during its implementation:

1. That the Federal Government publically acknowledge and support research findings, and indicate its concern, about the large number of teenage abortions, full term pregnancies, the great incidence of sexually transmitted diseases, and related health and social problems.



2. Through the Office of Education, provide trained, knowledgeable personnel to assist state and local educational agencies and communities in the exploration and development of education about human sexuality.

3. Provide funds to schools and communities willing to investigate the organization and development of education about human sexuality appropriate to their local and peculiar needs.

4. Acknowledge and/or establish model Family Life and Sex Education programs to assist those attempting to establish their own programs.

Finally, whether or not our young people should be involved in education about human sexuality is not the issue, but rather what kind and how much. We are convinced that with the support of the Federal Government through the proposed Senate Bill 2910, local communities and educational agencies can be assisted and served as they develop and implement that which is appropriate to their own special needs.

DEVELOPING FAMILY LIFE AND SEX EDUCATION PROGRAMS IN THE SCHOOLS

George H. Thoms & Mary Lee Tatum
Falls Church, Virginia

Schools cannot and should not "replace the personal relationship between parent and child or cancel the moral teachings of the Church; but a school program can be complementary to these, and alone is better than no sex education at all."[1] "The schools are the only institutions that can reach practically all the children over a substantial period of time. Both the easy to reach and the hard to reach are there in the classroom. As an educational institution, the schools are able to pass on the wealth of knowledge about human development, human behavior, and family life."[2]

Believing that the school should play an important role in education about human sexuality, the writers offer this systematic approach to the organization and development of family life and sex education programs in schools. The terms family life and sex education are used synonymously and although including information about human reproductive systems, have as their focus instruction about maleness and femaleness encompassing the sociological, psychological and physiological aspects of human growth, relationships and general development. In specific terms and concrete format, following is a suggested process for developing a Family Life/Sex Education Program within a school or school system.

I. Assess Need and Interest

Listen to what people and groups say. Get the feeling of the P.T.A.--those people who are supporters of band programs and athletic programs. Listen to the feelings of parents who work in the schools (not by questionnaire, but in person). Generally those feelings will be overwhelmingly positive because you are simply asking, "what do you want to do?" If the feelings are overwhelmingly negative, one should question whether it is productive to pursue the matter any further at this particular time.

II. Conduct Staff Investigation

Begin to assess what the community seems ready to accept through a committee of staff members--: some potential sex education teachers, perhaps the school psychologist and someone from the Superintendent's office. Meet on a regular basis to review what other school systems are doing in the country. There is no need to reinvent the wheel, and this is also a method whereby professionals may become aware of what is happening in sex education.

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[1]Wilson W. Grant - From Parent to Child (Grand Rapids: Zanderam Publishing House, 1973), p. 153

[2]ibid. p. 152

III. Form A Community/Staff Committee

After the staff committee feels it has gained an understanding of what is happening in sex education programs, then the school community committee is formed. This group could have as many as 15 to 20 people on it. It should be representative of both school and community: several teachers within whose disciplines sex education might be taught, representatives of various religious institutions, the local pediatrician or doctor, the school nurse, school psychologist, the PTA president and several other parents.

IV. Community/Staff Committee Tasks

A. As its first task, this Committee will review the material gathered by the Committee of School Staff. After becoming familiar with what is happening in sex education in various parts of the country, the question next to be dealt with is Who will the teacher be?

B. Explore Staffing - Studies have shown that the selection of the teacher (s) is the most critical aspect of beginning a program. Instruction can be developed in health, biology, the sciences, home economics, social studies, or even English. It has been our experience that selection of the teacher should be based on these criteria:

1) Someone who has the potential for gaining the trust of the faculty and community.

2) Someone who has good rapport with students: an empathetic feeling, warmth, and understanding of the students with whom he/she is dealing.

3) Someone who has a comfortableness about sex-related terms and the content of a human sexuality course. This ease would, of course, improve with training (discussed later).

C. Determine curriculum, grade level placement, and teaching strategies. In addition to considering who the teacher(s) should be, the issue of whether or not the course(s) should be required or elective must be dealt with. In this era of indecision about sexual behavior in the society as a whole we feel it is a mistake to require everyone's child to be in the program - no matter how badly he or she may seem to need it. When a parent is "forced" to remove a child from a required program, an angry situation may develop which will have negative impact on the program.

The curriculum should be geared to the grade levels at which instruction is planned. We should teach sex education not as "now we will have a class in sex education", but in terms of the larger ideas of human personality and sexual identity. Just as we would not discuss with a five year old the complicated interactions between human beings on a personal and/or conversational level, we would not discuss with that same five

year old complex ideas about sexual behavior. We have to gear what we teach, when we teach it, to the particular developmental level of the students we are teaching.

Teaching strategies should include (1) listening very carefully to what students are saying in the classroom, (2) reflecting back to them what the teacher thinks they are saying, (3) having them repeat and giving them the self-esteem involved in their repeating their ideas, (4) treating their ideas as valuable, (5) summarizing what they are saying individually, (6) summarizing at times what the class seems to be saying. Allowing them to hear what their peers think is extremely important, yet realizing and remembering that the instruction is being facilitated by an experienced and knowledgeable teacher. The teacher should know how to summarize in such a way that no one child dominates in terms of opinion, so that students don't go out of the classroom saying, "Well, so-and so said, so therefore it is true."

V. Curriculum Detailing and Instructional Parameters

As above, the school-community committee tasks are those of determining who the teacher or teachers will be, looking at what kind of curriculum they are most comfortable with, and then in great detail, writing the curriculum. Issues such as: should the teacher be allowed to draw on the blackboard, will contraception education take place, will education about abortions, homosexuality, and masturbation be allowed. Additionally, the task of the committee is to write in detail the limits within which the teachers may operate. Which media, books, and materials will be allowed in the classroom, e.g., should contraceptives actually be brought into the classroom or just talked about? This task could take as much as a year of regular meetings every two or three weeks. This is a critical step in the whole process.

VI. Community/Staff Committee Information Dissemination

After the committee finishes its detailed work about what should be taught, how it should be taught, and writes it all down, then the next major task in the process is that of disseminating the information to the community.

The committee's job is best accomplished by aggressively seeking to disseminate the information to the community. That is, by putting announcements in the PTSA newsletter, local radio stations announcing that information and a potential program will be discussed in the school auditoriums, and urging people to come out and listen to what the possibilities are for instruction in sex education. All of this will be used as additional input for the school-community committee's continuing work. The input will then be used to modify, if necessary, the school/community committee's direction.

VII. Appraisal, Rewrite, or Rejection

The committee then, after holding hearings to discuss the potential program, takes its feelings, its findings, its written documents to the school board. At this point it will either be

accepted, rejected, or asked to be modified.

Throughout the process, there should be ongoing communications with the school board, that body which will eventually approve or reject the final document, so that some feeling for whether or not the direction the committee is heading in is one that is acceptable to them. If the program is adopted, then starting the program at one grade level makes sense and is easier to deal with than trying to implement a program K-12.

VIII. Implementation

Start at one grade level, the level the school/community committee felt was most appropriate for its school or its community: perhaps the seventh, eighth, or ninth grade. Eventually, after the program begins, there must be constant review and scrutiny by the community, and regular reporting back to the school board or ruling body of the schools.

IX. Teacher Training

Very little teacher training is available. There are universities and colleges which offer some course work in human sexuality which serve the purpose of both dissensitzing to the language of human sexuality and that of providing good basic information. Social work agencies often conduct useful seminars. Begin to be acquainted with a good bibliography of different, effective methods of teaching. There are regional work shops held by the American Association of Sex Educators, Counselors, and Therapists, within a geographically possible distance from almost any school system. These are excellent and more information about them is available through AASECT, 5010 Wisconsin Avenue, N.W., Suite 304, Washington, D.C. 20016.

X. Review On-going Communications

The program begins and the review process continues; scrutiny continues; the work is never finished. The school/community committee should continue to meet on a regular basis, perhaps twice a year, to review and discuss parent feelings and school staff feelings, to look at materials, to review new materials, to get rid of materials that may have lost their appropriateness as the years go on. The school and the community must work together regularly to insure the effectiveness of the program.

The process of developing sex education programs as described in the preceeding pages has been condensed from a color video cassette "Sex Education: Developing a Program" produced by PM Productions at Georgetown University Medical School TV Studios. Additionally, Dr. George H. Thoms, Principal, and Ms. Mary Lee Tatum, Family Life and Sex Education teacher, have available through PM Productions the video cassette Sex Education: A Rationale For The Public Schools. Brochures describing the tapes and their availability may be obtained from PM Productions, #20 8th Street, S.E., Washington, D.C., 20003. Information about the Family Life and Sex Education program in which Dr. Thoms and Ms. Tatum are involved may be obtained by writing to George Mason Junior-Senior High School, 7124 Leesburg Pike, Falls Church, Va. 22043

COURIER-POST
Jersey P.M. Report

THURSDAY, JULY 6, 1978

Teen pregnancies on the rise in Jersey

TRENTON, N.J. (AP) — The New Jersey Department of Health says state efforts to prevent teenage pregnancies are failing.

Mitch Leon, a spokesman for the health department, said Wednesday schools' sex education programs "do not appear to be overwhelmingly successful."

He said while school officials are referring more students to family planning agencies and clinics, there are more young women becoming pregnant.

Births to unmarried women 18 years old and younger have increased over the past 10 years, according to Health Department reports.

In 1968, there were 4,105 births to unmarried young women; there were 5,868 in 1971 and 7,089 in 1976.

The increase came as the state's total birth rate was declining: 120,118 in 1968; 111,276 in 1971 and 90,540 in 1976.

The state Board of Education does not require schools to educate teenagers about contraception, said Monica Walsh, a Department of Education spokeswoman.

The board's only policy on sex education is that schools can offer separate classes for males and females provided the course content is the same, Ms. Walsh said.

Some people involved in sex education recognize that the public school programs are inadequate to convince teenagers to use contraceptives.

Mary Morse, a spokeswoman for the Mercer County area Planned Parenthood Association, says social problems make it more difficult for schools to deal with sexually active teenagers.

"If people feel they have no control over their lives they're not likely to use contraceptives," she said.

"I'm sure we don't even know enough about why kids are getting pregnant," Ms. Morse said.

She said health educators and family planners should try to learn more from teenagers themselves about why they become sexually active and become pregnant.

"There are a lot of special things in dealing with the whole person, what options they have and why they become sexually active in the first place or desire a child," she said.

"The time is past for going into the schools," Ms. Morse said.

Ann Lavine, a lobbyist for the Family Planning Public Affairs Office, a Trenton-based private organization, said, teenage pregnancies are "everybody's problem."

"Schools are not the sole answer but I don't think they can ignore it either," she said.

An Overview Of Adolescent Pregnancy: Is It an Epidemic?

Abstract

James F. Jekel, M.D., M.P.H.
Associate Professor of Public Health
Yale Medical School
New Haven, Ct. 06510

Many Americans, particularly the authors of a recent report from the Alan Guttmacher Institute, consider the current numbers of teenage births to constitute an "epidemic." This concept is questioned by demonstrating that the current phenomenon of adolescent pregnancy does not meet the epidemiologist's criteria for an epidemic, nor are the negative connotations of the word necessarily appropriate. Moreover, it is demonstrated that the medical (disease based) model is not appropriate to apply to a social phenomenon such as adolescent pregnancy.

Society's therapeutic response to adolescent pregnancy is fragmented and transient, due partly to the social desire to minimize the visibility of the problem, and partly due to deficiencies in our understanding of what services are needed and for how long and our lack of willingness to pay for such services. The current push for "primary prevention," while making a certain amount of sense at first glance, is also based on dubious assumptions, including the medical model.

Ultimately, our failure to understand the forces producing adolescent pregnancy and to provide adequate preventive and treatment services, is due to the lack of an adequate conceptual model for the role of adolescents in our society. Until such a model is established, our efforts may continue to be empirical and piecemeal, as were the disease control efforts prior to the development of the germ theory.

An Overview Of Adolescent Pregnancy: Is It An Epidemic?

James P. Jekel, M.D., M.P.H.
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The Phenomenon of Adolescent Pregnancy

Adolescent pregnancy is not a new phenomenon, and yet it is new in terms of the numbers of persons involved and the way it is socially perceived. In a recent national survey of programs for pregnant adolescents, one program was found that had been providing such services for 147 years (1). Nevertheless, the numbers of such pregnancies has been rising steadily, at least until the last few years. The national concern has been rising even more radpily, as illustrated by increasing numbers of articles in newspapers and magazines, talk shows and specials on television, Federal administrative initiatives (Secretary Califano's "Alternatives to Abortion"* and several bills focusing on adolescent pregnancy), and several special reports done for foundations and special groups (2-5). The titles of these latter reports vary from those with restraint (the Journal of School Health's "Special Issue: School-Age Parent" and the National Alliance Concerned with School Age Parents' "School-Age Pregnancy and Parenthood in the United States")

*More recently called "Teenage Pregnancy Initiative" and still more recently the "Teenage Pregnancy Objective."

to one showing concern ("Teenage Childbearing: Extent and Consequences") to one whose subtitle clearly takes a (negative) judgmental stance toward the phenomenon (The Alan Guttmacher Institute's "Eleven Million Teenagers: What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States.")

The concept of "epidemic" provides a number of questions with which to begin: 1) Do the numbers and rates justify the concept of an epidemic? 2) An "epidemic" is universally used for a bad event that afflicts a population: is adolescent pregnancy a "bad" thing? 3) Epidemiologists are concerned to search for causes of the diseases that reach epidemic proportions (and even those who do not). 4) In an epidemic, the society seeks to provide "treatment" for those who are ill; what are we doing about those so affected today? Is this response appropriate and adequate? 5) To use the term "epidemic" implies that a "disease" is loose among the population; is the medical model really appropriate when applied to pregnancy, even adolescent pregnancy? (i.e., is teenage pregnancy a "disease"?) 6) In seeking out the causes in the environment and way of life of a population, an epidemiologist is primarily concerned to discover how future cases can be prevented. Is a preventive orientation to future adolescent pregnancies realistic? This paper will seek to address each of these questions to some extent, although some of these questions will be more fully covered in subsequent papers.

Size of the Phenomenon

An excellent recent study demonstrated the changes occurring in adolescent pregnancy from 1961 to 1973 (6). The numbers of live births to women less than 15 years of age increased from 7,000 to 12,900 and the numbers born to those from 15 to 17 years of age increased from 178,000 to 238,000. At the same time, however, the number born to those 18 and 19 was declining from 424,000 to 366,000, so that the numbers of births to women under 20 did not change very much. However, when this is seen against the backdrop of a declining total number of births in the U.S. during the same period of time, the proportion of all live births to women less than 18 years of age increased from 4.4% to 8.0% during this 13 year span, and the proportion of all births to women less than 20 years increased from 14.3% to 19.7%. The increase in the proportion of all births was similar for whites and nonwhites. To put the data in perspective, they mean that one child in five is born to a woman who has not reached her 20th birthday, and almost one in 12 births in the country is to a woman who has not reached the 18th birthday.

The 10-14 year age group is the only 5 year age group that did not show a considerable drop in the age specific birth rate between 1961 and 1973. During this time interval, the age specific birth rates to women 35 and over dropped to less than half of what they were in 1961; for those from 20-34, the birth rates in 1973 were approximately half of the rates in 1961; and even for those 15-19, the birth rates had

dropped by one third. However, the birth rate for women 10-14 increased by almost 50% during this same period of time.

The changes in proportion of all births due to teenagers must be interpreted in light of both changes in the age specific birth rates and the size of the birth cohorts. Thus, the total number of births to teenagers levelled off in 1974 and actually declined to 595,000 in 1975 (provisional). The more recent decline has a number of implications, including the possibility that the numbers of adolescent pregnancies may continue to decline. It does not, however, necessarily give anyone the right to claim that specific initiatives, whether family planning, comprehensive programs, or political advocacy are responsible. In fact, many demographers have been anticipating a moderate decline in these numbers, due to the decline in birth rates reported above: There simply are fewer children coming along to be teenagers in the coming years. For example, the number of children in the 10-14 age group in 1975 was 3.3% less than in 1973, and could explain the drop observed in 1975 assuming more or less constant birth rates.* But in 1980, the number of women in the 10-14 age group will be only 83% of the number in 1973. If we have a 17% reduction in pregnancies among those 10-14, from 1973 to 1980, it may be only due to the reduced size of the group at risk. You might not, therefore, want to get on the bandwagon of advocacy for teenage parents, since it may have passed its peak.

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*This calculation omits the small number of deaths to children alive in 1970. When included, they would slightly increase the drop in numbers.

However, hopefully, our motivation for concern is based on something more than sheer numbers.

But is this an "epidemic," as the Alan Guttmacher Institute has implied? An epidemic is classically defined as "the unusual occurrence of disease." Is this "unusual"? One cannot base determinations of "epidemic" on the percentage of all births that are to teenagers, since this change was largely due to decline in the numbers born to older women. Nor can we cry "epidemic" on the basis of changes in rates, since there has been a decline in the age specific birth rate for every age group except the very youngest. It is only on the increase in numbers of births to teenagers that we could find support for the label of "epidemic," but that is not very convincing, because it is only due to an increase in the numbers able to give birth which was greater than the decline in rates. Moreover, it would appear that, even in numbers, we seem to have passed the peak. I would, therefore, suggest that the label "epidemic" is inappropriate on the basis of the demographic data alone, and can be dangerous if it gives rise to the kind of unreasoning responses that have often characterized society's behavior in the face of past epidemics.

Is Adolescent Pregnancy a "Bad" Thing?

The second question derived from the term "epidemic" is whether the phenomenon, even if it fits the quantitative criteria for an epidemic (which it doesn't), should be considered an evil. We don't usually talk

about an epidemic of blessings. This question has a number of component questions that must be considered separately. For example, we should ask: "Bad for whom? — for the young mother, or the child, or society, or her family?" The answers to these questions may be different. Also, we must ask: "Bad in what way?" It might be bad for education but good for family life, or bad for physical health but good for mental health. It might have positive benefits around the time of delivery and negative effects later on, or vice versa. In the two largest studies of urban teenage mothers, there is no doubt that many benefits were seen by the young parents over the short run, but as time passed the problems often became greater than for those with school-age pregnancies (7,8). Nevertheless, the experience is usually reported in mixed terms by the young mothers, and negative consequences must sometimes be inferred from such things as limited social life, broken marriages, economic difficulties, or frequent desperate efforts to control subsequent fertility (9). Whether some of these problems are due to the unhelpful response of society is another question that should be raised. Society may look at the issue of adolescent pregnancy in terms of the loss of productivity and independence of the young parents and their children subseuqnet to the teenage pregnancy. Perhaps most disturbing are some follow up studies of the children of these young mothers. Unpublished studies in New Haven, for example, suggest that there may be serious bonding problems in a majority of the children, and that a high proportion of the children may have health problems and/or abuse/neglect. However,

these dimensions have not been adequately studied and, at present, no firm conclusions can be drawn.

It does seem fair to say that, by some of the standard expectations of society in the areas of health, fertility, marriage, economic independence, and educational progress, teenage motherhood does create difficulties. However, even here, blanket condemnation would not seem to be appropriate.

The Causes of Adolescent Pregnancy

We have neither the time nor knowledge to go into a detailed discussion of the causes of adolescent pregnancy, which are many and individualized. It may be useful, however, to point out one "enabling" phenomenon that has been occurring over the last century or so: a drop in the age of menarche. According to Konner "in 1840, the average young woman in Europe and the United States menstruated for the first time at the age of 17; her modern counterpart reaches the ages of menstruation at about 12. ...The age of first possible parenthood has declined comparably, and early literary references to teen-age marriage and parenthood have been shown to be completely unrepresentative, exaggerated, or false." (10) We have long known that the population explosion and paralytic poliomyclitis were unexpected complications of better sanitation and disease control, and better nutrition; can it be that earlier teenage fertility is also? Undoubtedly improved nutrition and disease control have played an important role in allowing earlier menarche to occur, which in turn represents a new ingredient in the

ecological balance of human society. There is no simple solution here. It is unlikely anyone will propose promoting poor nutrition or more disease in order to delay menarche, and it would probably not be effective if tried.

The position of the adolescent as a useless element of society, the poverty of central cities and rural areas, the emotional needs of adolescents, the blurring of societal values, and the changes of sexual behavior patterns of adolescents all undoubtedly play causal roles. Multiple and complex causes suggest that changes would also have to be multiple and complex if the size and scope of adolescent pregnancy is to be reduced more rapidly than the demographic changes themselves predict.

Society's Response to Adolescent Pregnancy

Over the decades, society's response to the phenomenon of adolescent pregnancy has been almost as varied and complex as the problem itself. One response has been that of denial: By evicting pregnant school age women from further schooling and by forcing marriages, society has limited the visibility of the phenomenon. Both the increased numbers of adolescent pregnancies and changes in social values and communication have forced more visibility. In fact, one of the primary reasons for the current social interest is that whereas prior to the 1960's, many teenage mothers released their babies for adoption (and thus filled a social need), today most of the teenage mothers keep their babies. This makes the children more visible to society and yet less accessible to feed the demand for adoptive babies. The old patterns

of maternity homes served both of these interests, in that they hid the mothers during the pregnancy, and later provided most of these babies for adoption.

The new realities suggested that new service approaches were needed for the majority of mothers who kept their babies. During the early and middle 1960's, a number of pioneering community programs developed in such places as Baltimore, New York City, Syracuse, New Haven, Chicago, Philadelphia, and Los Angeles. These program emphasized the provision of a triad of services, usually in a facility geographically and administratively separate from the public schools. The three primary services offered were: medical care for the mother (and sometimes for the child); continuing education; and social services. Sometimes day care or other services were offered, but for the most part the major three services were offered in the context of crisis intervention. Administratively, these programs might have been based in a medical setting, a social service agency, or the board of education. Practically, most were underfunded and were patchwork aggregations of community services by dedicated people, and they were often held together by the sheer energy and personal magnetism of some of the founders. Despite their limitations, they helped to stimulate the concern and imagination of hundreds of communities around the nation, so that in a recent year the National Alliance Concerned with School Age Parents could publish a directory of more than 1000 programs providing at least some services to pregnant adolescents (11).

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Surprisingly, despite the general interest in, and promotion of, the triad of health, education, and social services, only 54 of the 1132 classified programs in the Directory (4.8%) contained all three services integrated into one program (although all three services might have been available in separate programs). Four hundred and five (35.8%) of the programs had two of the three basic services, usually education and social services, with the young mothers obtaining their medical care elsewhere, such as at a local clinic. Another 311 programs offered only one of the three "major" services, usually social services. An additional 176 programs were listed as providing abortion services to adolescents, 169 were listed as Planned Parenthood clinics offering services to teenagers, and 17 offered both abortions and family planning.

It is clear that most of the community programs are not truly comprehensive. This reflects problems of financing and coordination of other services in the community, as well as the history of the agencies from which they spring and the inevitable financial difficulties. Funds come from all levels of government as well as local and national voluntary agencies, with local and state governments providing most of the funds. There is no real suggestion of imminent Federal monies specifically for comprehensive programs for pregnant adolescents; most of the Federal funds come either through the States (as, for example, special education funds) or through reimbursement mechanisms (such as Medicaid funds).

One of the most disturbing findings of a national survey of programs for young mothers done by the National Alliance Concerned with School Age Parents is that there is a general lack of follow-through on the services available. That is, most of the national programs are what might generally be thought of as "crisis intervention"programs, providing services only during the "crisis" of the pregnancy, labor and delivery, and the immediate postpartum period. One of the basic findings of the largest evaluative study of teenage parent programs suggests that short term services usually produce only short term benefits (7).

It is possible to state, on the basis of the foregoing discussion, that this nation's "therapeutic" response to the phenomenon of adolescent pregnancy is far from impressive, on either a quantitative or qualitative basis. Therefore, any comments you might hear to the end that such programs haven't worked must be tempered by the understanding that, as a nation, we really have not tried comprehensive programs as a solution.

Primary Prevention - A Valid Concept?

If therapeutic programs have not really been tried, what about "primary prevention?" Wouldn't that be better in the first place? The term "primary prevention" was originated, or at least popularized, in medical circles by Dr. Hugh Leavell, who described three "levels" of prevention (Leavell's levels!) (12). The term was applied to the prevention of disease. First one must ask whether the medical (disease

based) model itself is appropriate to apply to early pregnancy. Is this reminiscent of an old era when pregnancy was an "illness"? According to Talcott Parsons, to be socially tolerable, illness, which otherwise is a form of deviance, must be nondeliberate in origin, and the afflicted individual must want to rid herself o the illness and seek competent help to do so. Society, in turn, exempts the person from responsibility for his or her condition, and the person is relieved of normal role obligations. As McKinlay has pointed out, (13) it is dubious that any of these four aspects of the Parsonian "sick role" apply very well to pregnancy, which is often wanted, and the help that is sought is to maintain and improve the pregnancy. Moreover, society does hold the woman responsible for the existence of her pregnancy and does not exempt her from most obligations. The exceptions to the latter are if there are serious complications of the pregnancy (where the concept of illness is easier to accept) or, ironically, in some areas pregnant adolescents are more than exempted from normal role obligations such as school — they are ostracized! MacGregor has emphasized the biological and social disadvantages of treating pregnancy as an illness (14). In fairness, it should be noted that there are still some who believe pregnancy should be considered a chronic illness (15).

Even if the medical model is useful (and that is dubious), one must distinguish between a disease and a symptom or complication of a disease. Is school age pregnancy a disease to be prevented, or is it a symptom of some other problem? There is evidence to suggest that many

of these pregnancies are wanted, either because the young woman finds something she needs in closeness with a man or because she believes she can make up for lack of love in ther own upbringing by having a child whom she will love and who, in turn, will love her (16). Some persons working with young mothers feel many pregnancies are an attempt by the young mother to ward off an impending depression or intolerable loneliness (16). If the pregnancy is not the disease but is a symptom or attempt to solve a problem, there is the danger that preventing one symptom may lead to another. What will take its place: drugs, alcohol, violence, suicide? Are they to be preferred if, indeed, this is the choice? Adolescent mothers already have an inordinately high suicide risk (17). Is enough known about the adolescent cultures to promote "primary prevention"? What does this concept mean to adolescents?

Assuming that Leavell's model does have usefulness, primary prevention means preventing the development of the problem first. This may be done in one of the two ways:

1. Health promotion. By this Leavell means using general methods of environmental and behavioral change, including good nutrition, sanitation, housing, and education. There seems to be little doubt, since school age pregnancy has a strong socioeconomic gradient, that general social measures, if applied over generations, would have an impact on adolescent fertility, but these changes are not likely to be within the power of a specific "program" to achieve. Klerman (18), for example, has emphasized the critical need to provide, early, a meaningful

role for young people, including some form of socially useful work and skills, preferably integrated with their educational experiences. Programs for family life education also fit in this category of "health promotion."

2. Specific promotion. The second subheading under primary prevention is "specific protection," i.e., a technically developed "bullet," an intervention with the capability of preventing a specific disease. The prototype in medicine is the vaccine. Are there specific techniques that can be used to prevent first pregnancies in teenagers? Contraceptives will prevent pregnancies, and abortions will prevent live births. But in what context can these be offered to young adolescents and to what extent should they be promoted?

Secondary Prevention

Leavell's second level of prevention is detecting the problem early and limiting the disability caused by the problem through effective therapy.

The increasing number of special, often comprehensive, school age parent programs, which are developing around the country (discussed above), are considered secondary prevention. They attempt to limit the medical, social, and educational disability from the school age pregnancy. It must be remembered also that secondary prevention, in the form of effective family planning assistance, may be primary prevention of a rapid subsequent pregnancy, which is especially important for medical reasons.

Ordinarily, in disease, primary prevention is considered more effective and efficient if it can be achieved, but secondary prevention is often the path of least resistance due to demand for services and clarity of the target population. Is this true for school age pregnancy? Is primary prevention more effective and efficient?

Family Life and Sex Education

Many believe that an effective curriculum of family life and sex education in the schools would help teenagers understand the consequences of their actions and, if they must be sexually active, at least be more knowledgeable in the use of contraceptive methods. There are several problems with this belief.

First, the author knows of no effective demonstration that family life and sex education programs have a demonstrable demographic impact. Only Sweden has had long term experience with providing sex education for young people, and "the effects of (this) program on sexual behavior and use of fertility control are not clear" (19). In any case, they would be more likely to be effective if there also was good access to family planning assistance and devices.

Second, in the current social atmosphere, it is unlikely that the majority of communities and school systems will permit an effective family life and sex education program in the near future. What needs to be done first is to establish demonstration programs and determine their effects on fertility and other variables.

Family Planning

There have been attempts to create programs to give sexually active teenagers family planning devices and information (20). The Mt. Sinai program in Baltimore contained an evaluation of subsequent reproductive performance, which, although lacking a control group, did not show any definite reduction of pregnancies because of the program (21,22). Drop out rates were high, and among those remaining in the program there was still a moderate pregnancy rate (6 per 100 person-years).

Some persons have questioned the likelihood that school age women, particularly those from low income and limited educational backgrounds, will make effective use of contraceptive methods. In one study, school attendance, not contraceptive use, was the strongest predictor of reproductive performance (23).

There is a problem with contraceptive programs that concerns the target group. As in many areas of public health, those at highest risk are least likely to use the services. In an evaluation of a teenage family planning program in one medium sized New England city, Feinberg (24) found that almost all the teenagers who used the family planning services came from the surrounding suburbs, and few users came from the inner city target group.

Another problem complicates the provision of contraceptive services for teenagers. In the past the legal rights of minors to seek contraception, abortion, or treatment for venereal disease without parental consent have been questioned. By 1976, 45 states had reduced the age

of majority to 18 years; 44 states permitted an 18-year-old to seek her own medical care, almost always including prenatal care and abortion (25). Nevertheless, there is still resistance in the medical community, particularly in this time of frequent medical malpractice suits, to do what was, until recently, thought to be forbidden by the common law (or judicial opinion).

The problem is even more difficult for women under 18 years, the group specifically of concern in the primary prevention of school age pregnancy. Although a number of states have statutory approval to provide contraceptives to minors under 18 years, for the most part, one must invoke the "mature minor doctrine," which means that a minor "who is sufficiently intelligent and mature to understand the nature and consequences of a treatment which is for her benefit. . ." may give permission for care without parental approval or knowledge (25). Acceptance of this doctrine is not universal, but it is growing. Physicians nevertheless are still ofteh hesitant to provide services without parental consent to women under 18 years.

Abortion

There is no question that a significant proportion of pregnancies in women under 18 years are now aborted (26). This proportion may increase as attitudes toward abortion change and if the accessibility of abortion increases in many areas of the country. What is not clear is whether public programs should in any way encourage teenagers to consider

abortion or attempt to provide education about abortions as a part of family life and sex education programs. There are serious moral questions involved, and the psychological sequela of abortions to adolescents are not clear. It would seem that the most that could or should be done, at present, is to increase the accessibility of abortion services for adolescents. Abortion is also sometimes involved in the legal questions about parental consent.

Conclusions

In conclusion, it would seem that it is inappropriate to apply the concept of "epidemic" to adolescent pregnancy at this time. Rather than resulting from some rather sudden disequilibrium in society, it has resulted from the interaction of numerous biological and social forces over a considerable period of time. Hence, in the langugage of the epidemiologist, the phenomenon is closer to the idea of "endemic" than "epidemic." This does not mean that there is no problem, but the successful responses to endemic problems have historically been those of broad scale social changes rather than technologic bullets, although the latter have sometimes played a role.

Moreover, the medical model is probably not very appropriate to apply to adolescent pregnancy, and its extension into the concept (as well as application) of "primary prevention" is fraught with danger. It may be that the lack of an adequate conceptual model for adolescent pregnancy is ultimately responsible for our apparent inability as a nation to develop a consistent or comprehensive approach to helping adolescent mothers and their families.

We are presently more certain that advocacy for adolescent parents is needed than we are certain we know what to advocate. Hopefully, some of these issues will become clearer from this conference.

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Yale University New Haven, Connecticut 06510

SCHOOL OF MEDICINE
Department of Epidemiology and Public Health
Health Policy Project
60 College Street

June 19, 1978

Senator Harrison A. Williams
Chairman, Senate Committee on Human Resources
4230 DSOB
Washington, D.C. 20510

Dear Senator Williams:

My name is James Jekel, and I am writing comments on the draft of the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978. I am a physician with certification by the American Board of Preventive Medicine. I have been teaching at Yale University for 11 years and am currently Associate Professor of Public Health. During this time my main area of research has been in the area of school age pregnancy and programs for adolescents who have become pregnant. I am an author of a monograph and more than 20 papers concerned with adolescent pregnancy and comprehensive programs to serve them. I have also worked as a member of the board of directors of the Young Mothers Program in New Haven, Ct., and the National Alliance Concerned with School Age Parents.

I am encouraged at the recent evidence of concern on the part of Congress for an issue that has been of concern to many of us for more than a decade, but I am worried that the bill, in its draft form, is not sufficiently focused and does not guarantee an adequate emphasis on the care for pregnancies which do occur and are brought to term .

To start, I am concerned with the implication that all teenagers are adolescents (sec. 2(a)(2) says there were 600,000 adolescents who carried their babies to term. Over half of the 600,000 were deliveries to 18 and 19 year olds, many of whom were married.) I believe the bill should more clearly focus on those under age 18.

I am also disturbed about the bill's assumption that we can prevent many more teenage pregnancies than we are now doing. The evidence for this is weak, and is mostly based on surveys which suggest that many of the currently delivered young teenage pregnancies were unwanted. The belief that most, even many, of the first pregnancies now occurring to young adolescents are unwanted is, to my judgment, incorrect. Motivation is so complex that one cannot obtain reliable responses by interviews. Most likely the motivation was mixed, with some feelings for and some against pregnancy. However, mixed motives are usually sufficient to preclude the taking of preventive action. Most inner city teenagers I have heard, white and black, have stated that they wanted to have someone to love (i.e., the

baby) and someone to love them, and someone to give the kinds of things they don't think they had. The responses to interviewers are of dubious validity, to my mind, both because the young people may not know their real motivation, because motivation changes with time, and because they may give answers they think would be most appropriate. Moreover, many young teenagers would not take a specific preventive approach, such as the pill or an IUD, because to do that would be to admit to themselves they planned to be immoral by their standards. In the moment of love or pressure from young men, whom they like, however, spontaneity does not seem to have the same negative connotations that a "planned" prevention would mean to them. Thus, their understanding of and belief in moral behavior may actually hinder effective prevention. I also have serious medical concerns about giving young teenagers either the pill or the IUD, and I know of no other contraceptives that would have comparable use-effectiveness.

I certainly am in favor of increasing the availability of contraceptive services to a reasonable level, but there are already existing Federal efforts in this direction, which may be expanded further by other bills currently submitted. Putting still more money from this bill into contraceptive services for all sexually active teenagers would create duplication between programs and would diminish the resources available for those who decide to carry the pregnancies to term, and for the primary prevention of future pregnancies among this high risk group. I have detailed my serious concerns about ignoring "secondary prevention" in a recent paper published in the Journal of School Health; this paper is attached as "Appendix A" to this written statement. My special concern for the prevention of the rapid second child to teenagers comes in part from our own studies; a paper explaining my concern is attached as "Appendix B."

Implicit in the primary prevention approach is the assumption that many of the young adolescents who deliver would readily make use of contraceptives if they were only available, or would do so with a minimum amount of public information and "education." The former view is not supported by the New Haven experience, where after the 1965 Supreme Court decision, contraceptives became readily available and are now offered through a variety of sources, including a special Health Dept. clinic in a housing project, Planned Parenthood clinics, hospital clinics, and neighborhood health centers, in addition to private physicians. The rate of first young pregnancies remains high, even in the population of a strong neighborhood health center that offers every pregnancy prevention service.

The latter view, that "education" would lead to effective use of prevention, goes against the generally disappointing results of community-based behavior modification efforts. I would, however, support a series of community-based primary prevention efforts using a variety of methods on a demonstration basis, if careful evaluative research were included in each. There simply is too little known to state how best to achieve "primary prevention" in adolescents.

I am pleased with the emphasis in the current bill on improving, strengthening, and building on existing programs rather than substituting for local funding. The idea of improving "linkages" is a good one, but if the mechanism is not carefully defined in the bill, the development of regulations, and their subsequent administration, could become a nightmare and be seriously delayed. In my judgment, the best approach to the administration would be to turn the responsibility over to the states, after they have developed a state plan for adolescent pregnancy, showing the existing and potential statewide links between education, health, social services, and day care, etc. The states would then give money to the communities to use to build and link services in their own areas. I have seen this general approach work well in Connecticut (see Appendix C, which is a report of a State of Connecticut program that was able to establish and improve many comprehensive adolescent pregnancy programs around the state by using a limited amount of money as leverage to draw out, link, and focus community money and efforts.) Moreover, other states have demonstrated how a State department with the will and some resources can be effective in establishing and linking services (Michigan and Oklahoma may be cited as states that are making progress in this regard.)

Another reason the States must be involved is that if project grant applications must come to the Federal level, the most successful grant applications will come from the strongest programs who already have the ability and the experience required for successful grantsmanship. Therefore, the monies would help the stronger programs rather than those in most need of help. State personnel are in a better position to judge local need and potential than is the Federal government, and are better able to monitor the progress and to provide technical assistance to local programs.

Also, the entire effort would need a high quality program of technical assistance to the States and to local efforts, which should be receiving support through this bill.

Two of the most important services are missing from the first draft of the bill: pregnancy testing and day care. Pregnancy testing is essential if the young mothers are to have early access to care. Day care is necessary if they are to receive the long term follow-up which is necessary to maintain the short term gains demonstrated by evaluative research.

Last, there is inadequate evaluation built into this bill. Unless money is specifically appropriated for a major evaluation effort (I would estimate this would take 2-3% of the appropriated money), at the end of 5 years Congress will not be sure that the program has accomplished its objectives.

I hope these comments are helpful. I would be willing to expand on these points or to address other issues. Please write or call (203) 436-4205.

Sincerely,

James F. Jekel, M.D., M.P.H.
Associate Professor of Public Health

JFJ:fw
encl.

"APPENDIX A"

Primary or Secondary Prevention of Adolescent Pregnancies?

James F. Jekel, MD, MPH

It is an appropriate time to reconsider the importance of prevention in health because study after study appears showing less than spectacular resulting benefits from therapeutic health services. Indeed, health, education, and welfare services are being subjected to increasing attack because they are showing signs of collapse in the face of modern demands. In the educational system, urban and rural youth graduate from high school (or drop out), functionally illiterate. The welfare system, instead of supporting families, forces them to break up, and the system is misused by thousands who do not qualify. The health system has failed to keep up organizationally, financially, and educationally with the impact of technology and specialization. In the health field, lip service is paid to quality and continuous, comprehensive, preventive care, but effective examples of these generalizations are difficult to find at a level of study larger than an unusually astute and dedicated individual practitioner.

There are few groups in the population with more needs than young women under 18 years of age, who are still in high or junior high school and are pregnant or have already become mothers. There were slightly more than 250,000 such women in 1973.[1] These young mothers suffer educational and social discrimination, often to the point of ostracism, with the combined effect of poor health for mother and child, educational and economic deprivation, unsatisfactory social and marital lives, and evidence of maternal deprivation (or worse) in the children.

In the middle and late 1960s there was considerable optimism that community attitudes were changing, and that special programs of services to these women, coupled with improved availability of contraception and family life education, would reduce subsequent pregnancies to those already young mothers and would even reduce the rate of young women getting pregnant. This optimism has been replaced in the 1970s by discouragement as the numbers of school age parents have appeared to rise, programs for school age parents are overfilled, and "repeaters" are seen all too often.

These impressions from program people are not in error. Between 1968 and 1973 the number of births to women under 18 increased from 203,000 to 251,000 per year (a 24% increase in 5 years.)[1] This was due to the greater number of teenagers, but the change in age-specific pregnancy rates was also disappointing. The 15-19 year age group did have a 9% decrease in birth rate from 1968-1973, but this was a far smaller decrease than that for any of the older age groups (eg, the 20-24 year age group had a 28% decrease in the same period). Moreover, the 10-14 year age group showed a 30% increase in age-specific birth rates in the same period of time.

This has led to an increasing cry from those working with school age mothers for "primary prevention," ie, finding ways to keep girls less than 18 years of age from becoming pregnant. There are, however, theoretical, practical, and cost benefit reasons to question heavy dependence at this time on "primary prevention" of school age pregnancy.

THEORETICAL PROBLEMS WITH PRIMARY PREVENTION

The term "primary prevention" was originated, or at least popularized, in medical circles by Dr. Hugh Leavell, who described three "levels" of prevention (Leavell's levels!).[2] The term was applied to the prevention of disease. First one must ask whether the medical (disease based) model itself is appropriate to apply to early pregnancy. Is this reminiscent of an old era when pregnancy was an "illness"? According to Talcott Parsons, to be socially tolerable, illness, which otherwise is a form of deviance, must be nondeliberate in origin, and the afflicted individual must want to rid herself of the illness and seek competent help to do so. Society, in turn, exempts the person from responsibility for his or her condition, and the person is relieved of normal role obligations. As McKinlay has pointed out,[3] it is dubious that any of these four aspects of the Parsonian "sick role" apply very well to pregnancy, which is often wanted, and the help that is sought is to maintain and improve the pregnancy. Moreover, society does hold the woman responsible for the existence of her pregnancy and does not exempt her from most obligations. The exceptions to the latter are if there are

serious complications of the pregnancy (where the concept of illness is easier to accept) or, ironically, in some areas pregnant adolescents are more than exempted from normal role obligations such as school—they are ostracized! MacGregor has emphasized the biological and social disadvantages of treating pregnancy as an illness.[4] In fairness, it should be noted that there are still some who believe pregnancy should be considered a chronic illness.[5]

Even if the medical model is useful (and that is dubious), one must distinguish between a disease and a symptom or complication of a disease. Is school age pregnancy a disease to be prevented, or is it a symptom of some other problem? There is evidence to suggest that many of these pregnancies are wanted, either because the young woman finds something she needs in closeness with a man or because she believes she can make up for lack of love in her own upbringing by having a child whom she will love and who, in turn, will love her.[6] Some persons working with young mothers feel many pregnancies are an attempt by the young mother to ward off an impending depression or intolerable lonliness.[6] If the pregnancy is not the disease but is a symptom or attempt to solve a problem, there is the danger that preventing one symptom may lead to another. What will take its place: drugs, alcohol, violence, suicide? Are they to be preferred if, indeed, this is the choice? Adolescent mothers already have an inordinately high suicide risk.[7] Is enough known about the adolescent cultures to promote "primary prevention"? What does this concept mean to adolescents?

Assuming that Leavell's model does have usefulness, primary prevention means preventing the development of the problem first. This may be done in one of two ways:

1. Health promotion. By this Leavell means using general methods of environmental and behavioral change, including good nutrition, sanitation, housing, and education. There seems to be little doubt, since school age pregnancy has a strong socioeconomic gradient, that general social measures, if applied over generations, would have an impact on adolescent fertility, but these changes are not likely to be within the power of a specific "program" to achieve. Klerman,[8] for example, has emphasized the critical need to provide, early, a meaningful role for young people, including some form of socially useful work and skills, preferably integrated with their educational experiences. Programs for family life education also fit in this category of "health promotion."

2. Specific Protection. The second subheading under primary prevention is "specific protection," ie, a technically developed "bullet," an intervention with the capability of preventing a specific disease. The prototype in medicine is the vaccine. Are there specific techniques that can be used to prevent first pregnancies in teenagers? Contraceptives will prevent pregnancies, and abortions will prevent live births. But in what context can these be offered to young adolescents and to what extent should they be promoted?

Secondary Prevention

Leavell's second level of prevention is detecting the problem early and limiting the disability caused by the problem through effective therapy.

The increasing number of special, often comprehensive, school age parent programs, which are developing around the country (now over 750), are considered secondary prevention. They attempt to limit the medical, social, and educational disability from the school age pregnancy. It must be remembered also that secondary prevention, in the form of effective family planning assistance, may be primary prevention of a rapid subsequent pregnancy, which is especially important for medical reasons.

Ordinarily, in disease, primary prevention is considered more effective and efficient if it can be achieved, but secondary prevention is often the path of least resistance due to demand for services and clarity of the target population. Is this true for school age pregnancy? Is primary prevention more effective and efficient?

PROBLEMS WITH PRIMARY PREVENTION OF SCHOOL AGE PARENTS

There are three major types of primary prevention programs advocated to reduce the numbers of first school age pregnancies. Each of these has problems at the present time.

Family Life and Sex Education

Many believe that an effective curriculum of family life and sex education in the schools would help teenagers understand the consequences of their actions and, if they must be sexually active, at least be more knowledgeable in the use of contraceptive methods. There are several problems with this belief.

First, the author knows of no effective demonstration that family life and sex education programs have a demonstrable demographic impact. Only Sweden has had long-term experience with providing sex education for young people, and "the effects of (this) program on sexual behavior and use of fertility control are not clear."[9] In any case, they would be more likely to be effective if there also was good access to family planning assistance and devices.

Second, in the current social atmosphere, it is unlikely that the majority of communities and school systems will permit an effective family life and sex education program in the near future. What needs to be done first is to establish demonstration programs and determine their effects on fertility and other variables.

Family Planning

There have been attempts to create programs to give sexually active teenagers family planning devices and information.[9] The Mt. Sinai program in Baltimore contained an evaluation of subsequent reproductive performance, which, although lacking a control group, did not show any definite reduction of pregnancies because of the program.[11,12] Drop out rates were high, and among those remaining in the program there was still a moderate pregnancy rate (6 per 100 person-years).

Some persons have questioned the likelihood that school age women, particularly those from low income and limited educational backgrounds, will make effective use of contraceptive methods[13,15] In one study, school attendance, not contraceptive use, was the strongest predictor of reproductive performance.[13]

There is a problem with contraceptive programs that concerns the target group. As in many areas of public health, those at highest risk are least likely to use the services. In an evaluation of a teenage family planning program in one medium sized New England city, Feinberg[16] found that almost all the teenagers who used the family planning services came from the surrounding suburbs, and few users came from the inner city target group.

Another problem complicates the provision of contraceptive services for teenagers. In the past the legal rights of minors to seek contraception, abortion, or treatment for venereal disease without parental consent have been questioned. By 1976, 45 states had reduced the age of majority to 18 years; 44 states permitted an 18-year-old to seek her own medical care, almost always including prenatal care and abortion.[17] Nevertheless, there is still resistance in the medical community, particularly in this time of frequent medical malpractice suits, to do what was, until recently, thought to be forbidden by the common law (or judicial opinion).

The problem is even more difficult for women under 18 years, the group specifically of concern in the primary prevention of school age pregnancy. Although a number of states have statutory approval to provide contraceptives to minors under 18 years, for the most part, one must invoke the "mature minor doctrine," which means that a minor "who is sufficiently intelligent and mature to understand the nature and consequences of a treatment which is for her benefit . . ." may give permission for care without parental approval or knowledge." Acceptance of this doctrine is not universal, but it is growing. Physicians nevertheless are still often hesitant to provide services without parental consent to women under 18 years.

Abortion

There is no question that a significant proportion of pregnancies in women under 18 years are now aborted.[18] This proportion may increase as attitudes toward abortion change and if the accessibility of abortion increases in many areas of the country. What is not clear is whether public programs should in any way encourage teenagers to consider abortion or attempt to provide education about abortions as a part of family life and sex education programs. There are serious moral questions involved, and the psychological sequela of abortions to adolescents are not clear.[14] It would seem that the most that could or should be done, at present, is to increase the accessibility of abortion services for adolescents. Abortion is also sometimes involved in the legal questions about parental consent.

COST-EFFECTIVENESS ISSUES IN PRIMARY PREVENTION

The CDC gave the 1973 abortion ratio for women under 15 years as 1,237 abortions per 1000 live births; a minimum estimate from the same source for the abortion ratio for those 15-17* years would be 600/1000 live births. This means that approximately 410,000 pregnancies occurred to women under 18 years in 1973 and about 160,000 of these (40%) ended in abortion. This was at a time when abortions were not everywhere easily accessible to adolescents, especially without parental consent. It is clear that, regardless of what is thought of abortions from a moral or health point of view, abortions now represent a major form of "primary prevention" of live births to young mothers. It is possible that if legal abortions become unavailable, contraceptives would take their place, but that is doubtful in most cases of adolescent pregnancy.

Under the assumption of no abortions, the problem of school age parenthood would almost double over a short period of time. Congress recently prohibited payments for abortions with Medicaid funds, but the impact of this at the moment is unclear. Therefore, subsequent calculations would assume the fertility rates and abortion ratios that existed in 1973.

It is also likely that the numbers of adolescent deliveries will start dropping in a few years due to the declining cohort sizes, which, in turn, are caused by the falling fertility rates in the 1960s and early 1970s. For the following calculations, cohorts of 4 million young people are assumed in each year of age, of which 2 million are assumed to be young women.

What would be the cost of a family life and sex education program over four years in junior high and high school? Assuming that the average yearly school costs per student in these grades are $1500 and that 10% of the educational resources would go into the family life and sex education program for four years of their education, the cost would be $150 per year per student

*The CDC reported these only as 539/1000 for age 15-19.

or $2.4 billion per year (16 million students x $150 per student). The value of these programs would be greater than just fertility control, of course, but in the absence of good studies, it seems unlikely that greater than a 10% reduction of under-18 pregnancies (or deliveries) would occur from the addition of such a program. The under-18 fertility benefits from such a family life and sex education program, under these assumptions, would be a yearly reduction of about 25,000 deliveries per year to women under 18 years. That implies a cost of about $96,000 to prevent one pregnancy, if all the family life and sex education effects were assigned to fertility.*

If the approximately 225,000 adolescents carrying their first pregnancy to term were receiving intensive family life and sex education services as a part of comprehensive programs, and if 20% of the $1500 per year put into these students' education were put into this subject (or $300 per year per pregnant student), the cost would be $67.5 million per year. Evaluative studies have suggested that perhaps a 25% reduction of rapid subsequent pregnancies (under age 18) would occur.[11] This would mean preventing about 6500 of the 26,00 or more second and third deliveries before age 18. An investment of money 3% as large would prevent about one fourth as many births, under these assumptions. Of course, it is to be expected that there would be other important benefits from family life and sex education in both settings, which are not considered here.

One fact not always known is that the prematurity and perinatal mortality rates for second and third birth order deliveries to adolescents are much greater than the same risks for first births to adolescents, even though the adolescents are, on the average, younger at the time of the first births.[1] It may be that the adolescent woman does not tolerate the repeated stresses of pregnancy as well as she would later. This provides a solid, medically based reason for strong programs to help adolescents prevent subsequent pregnancies while still of school age.

DISCUSSION

The argument of this article has been to remind everyone that in complex social-medical phenomena, the simplicity and high benefit-to-cost ratios of, for example, immunization programs, do not exist for primary prevention. It is dangerous, therefore, to assume, without supporting data, that primary prevention is necessarily the best, or even a good, programmatic approach to adolescent pregnancy at this time. Theoretical, practical, and benefit-to-cost problems exist, which make the concept of "primary prevention" difficult to apply in a simplistic manner to adolescent pregnancy.

This does not mean that better ways to assist adolescents in preventing first pregnancies should not be explored. The most basic steps, however, would appear to be the most important at this time, and these steps are more "enabling" than "promotive" in nature: every family and every adolescent should have easy access to contraceptive and abortion education and services, should they choose to make use of them. At this time, active, organized promotion of these services would appear to be more efficient in the context of programs for those adolescents who have already had a pregnancy.

CONCLUSIONS

1. There are theoretical, practical, and financial problems with organized programs for the "primary prevention" of pregnancies to adolescents. Organized primary prevention programs will probably not cause a major drop in adolescent fertility rates in the absence of considerable economic, social, and attitudinal changes in the society.

2. Despite the many problems, abortions represent a major form of primary prevention of births to adolescents.

3. At this time, limited resources are probably better spent on providing easy access to contraceptive and abortion education and services, and on intensive programs for those who already have had pregnancies, rather than on a large organized program in primary prevention.

*The point here is *not* to consider whether such a cost, if accurate, would produce sufficient benefits to make it worthwhile; rather the purpose is to develop a model for comparing the advantages of two different approaches.

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James Franklin Jekel, MD, MPH, is Associate Professor of Public Health, Department of Epidemiology and Public Health, Yale Medical School, 60 College Street, New Haven, Connecticut 06510.

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"APPENDIX B"

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A Comparison of the Health of Index and Subsequent Babies Born to School Age Mothers

JAMES F. JEKEL, MD, MPH
JEAN T. HARRISON, MPH
D. R. E. BANCROFT, MPhil
NATALIE C. TYLER, RN, BA
LORRAINE V. KLERMAN, DrPH

This study of school age mothers reveals that the risk of prematurity and perinatal death increases greatly in their second and third pregnancies.

Introduction

Approximately 350 special programs have been developed in America over the last 10 years which provide medical, educational, and social services to school age parents. The medical component of these programs varies considerably; some programs merely refer clients elsewhere for medical care and some provide obstetric and/or pediatric care along with educational and social services. This paper reports some of the findings from a 5-year prospective evaluative study of a comprehensive program for school age mothers which integrated obstetric care with other services. The health at birth of the index infant (the product of the pregnancy which brought the mothers into the special program and, hence the research sample) is compared with the health of subsequent infants born to the same mothers.

An earlier report from this project concluded that the infants born to mothers served by the comprehensive program were significantly more healthy at birth than were infants born to a control group who received traditional obstetric clinic care.[1] The questions being considered in the present paper are (1) did the apparent health benefit for the index infant also hold for infants born subsequently?; and (2) if not, why not?

The Special Program

The Young Mothers Program (YMP) in New Haven, Connecticut, provided educational and special services through the Polly T. McCabe Center as well as obstetric and social services through the Yale-New Haven Hospital, where a special clinic was established to serve school age mothers exclusively. Continuity of care was emphasized from the 7th month on, and the obstetrician or nurse-midwife who provided prenatal care was usually the one who delivered the baby (or at least was present at the delivery) and followed the mother through her postpartum period. The social workers held two or three intake interviews with each young mother and then saw her as needed. Group sessions were offered at which a wide range of topics was discussed

Dr. Jekel, Ms. Harrison, Mr. Bancroft, and Ms. Tyler are affiliated with the Department of Epidemiology and Public Health, Yale University School of Medicine, New Haven, Connecticut 06510. Dr. Klerman is with the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Massachusetts. This study was supported by Grant MC-R-090048 from the Maternal and Child Health Service, Health Services and Mental Health Administration, Department of Health, Education, and Welfare. This article was presented at the 100th Annual Meeting of the American Public Health Association, November 13, 1972, Atlantic City, New Jersey.

relevant to pregnancy, delivery, contraception, child care, and relationships with men. Many of the young mothers were no longer eligible for the YMP clinic during their subsequent pregnancies because of age and some who were eligible were not referred to the special clinic or did not choose to return to it. Therefore, for most subsequent deliveries, prenatal care was obtained in the regular obstetric clinics.

The Study Method

The health at birth and in the immediate postpartum period of 180 index infants was compared with that of the first 103 subsequent infants born to a cohort of 180 young mothers who registered for prenatal care for their index pregnancy in the Young Mothers Clinic of the Yale-New Haven Hospital between September 1, 1967, and June 30, 1969. All of the young mothers were under 18 years, unmarried, and residents of New Haven at the time they registered for care in the special obstetric clinic. Most of them (95 per cent) were nonwhite, and most were poor; 10 had delivered one infant previously and two more had delivered twice prior to intake into the program. The primary data sources were hospital, clinic, and emergency room records from the Yale-New Haven Hospital. These data were supplemented by records from the Hospital of St. Raphael, the only other hospital in the New Haven area, and from clinicians' rating forms, school records, and postpartum interviews. All of the index babies and all but two of the 103 subsequent babies were delivered at the Yale-New Haven Hospital. Therefore, the primary sources of data were comparable for almost all of the deliveries.

Findings

Method of Termination

By the end of the follow-up period, January 31, 1972, 79 of the 180 mothers in the study population were found to have delivered one or more subsequent infants of 20 weeks gestation or more at the Yale-New Haven Hospital, and they had delivered a total of 103 babies. In addition, 21 spontaneous abortions were recorded among 18 mothers, 22 medically induced abortions were found among 21 mothers, and one young mother had a self-induced abortion. The large number of induced abortions suggests that teenagers will choose to terminate a subsequent pregnancy when the alternative of abortion is legal and available.

Comparison of Health at Birth among Index and Subsequent Babies

The most striking finding was the significantly higher risk of perinatal mortality and prematurity among the 103 subsequent infants than among the 180 index infants.

SURVIVAL

Nine of the 103 subsequent infants died in the perinatal period compared to two of the 180 index infants. Among the nine subsequent perinatal deaths there were eight hebdomadal deaths and one stillbirth; two of these infants had the same mother. The subsequent infants, therefore, had a rate of death almost 9 times that of the index infants. A difference this large would occur by chance in less than one case in 1000. Clearly, subsequent babies born 2 to 4 years (mostly less than 2 years) following an initial school age pregnancy had a significantly higher risk of perinatal death than did their older siblings.

PREMATURITY

Twenty-eight of the subsequent infants (27 per cent) were of low birth weight, under 2500 gm (Table 1), which is over twice the proportion of prematures in the index group, and is even higher than the 23 per cent premature rate reported by Waters in 1969 for subsequent deliveries to young mothers.[2] Low birth weight is associated with, and is presumably a causative factor in, most deaths around the time of birth. The range of the birth weight in the nine infants who died was between 580 and 2220 gm. Only two weighed over 2000 gm. Thirty-two per cent of the infants of low birth weight died; none died who weighed 2500 gm or more.

Factors Associated with High Risk

Two factors are apparent. The study population delivered less healthy babies in subsequent deliveries than in the initial ones despite the fact that the mothers were older. Second, prematurity was the most important immediate cause of perinatal death. The following will be considered

TABLE 1—Obstetric Outcomes among Index and Subsequent Infants

	Index (N = 180)		Subsequent (N = 103)	
Outcome	No.	%	No.	%
Survival				
Perinatal death	2	1.1	9	8.8
Living infants	178	98.9	94	91.3
Total	180	100.0	103	100.0
	$\chi^2_1 = 8.26, p < 0.01$			
Birth weight				
Less than 1000 gm	2	1.1	3	2.9
1000–2499 gm	19	10.6	25	24.3
2500+ gm	159	88.3	75	72.8
Total	180	100.0	103	100.0
	$\chi^2_1 = 11.04, p < 0.01$			

TABLE 2—Obstetric Outcomes among Index and Subsequent Babies Born at Yale-New Haven Hospital, by Birth Order

Outcome	Birth Order 1 No.	1 %	2 No.	2 %	3 No.	3 %	Total No.	Total %
Survival								
Perinatal death	1*	0.6	6	7.1	4	14.3	11	3.9
Living infants	167	99.4	79	92.9	24	85.7	270	96.1
Total	168	100.0	85	100.0	28	100.0	281*	100.0
Birth weight								
Less than 1000 gm	1	0.6	2	2.4	2	7.1	5	1.8
1000–2499 gm	17	10.1	16	18.8	10	35.7	43	15.3
2500+ gm	150	89.3	67	78.8	16	57.1	233	82.9
Total	168	100.0	85	100.0	28	100.0	281*	100.0

* Two subsequent infants born at the Hospital of St. Raphael are excluded from this analysis.

as possible reasons for the high rate of prematurity: parity, delivery-to-conception intervals, prenatal care, and differences between mothers.

Parity

The number of previous deliveries was associated significantly with survival. Considering index and subsequent deliveries at the Yale-New Haven Hospital only, first births had a risk of perinatal death of less than 1 per cent, second births 7 per cent, and third births 14 per cent. The corresponding prematurity rates among these infants were 11 per cent, 21 per cent, and 43 per cent (Table 2).

For women in their twenties, second deliveries involve less risk of prematurity and perinatal loss than first deliveries, which is in contrast to the pattern observed among these teenagers.[3] The increased risk in subsequent pregnancies among these young mothers appears to have resulted from the interaction between age and parity, i.e., high parity in a young mother produced high risk.[4] The mechanisms for this interaction may be physiological factors, such as nutritional deficits and/or hormonal immaturity, or social and environmental factors, such as poverty and inadequate health care.

Delivery-to-Conception Interval

In order for a woman to have several pregnancies in her teens,* conceptions must occur at short intervals. Possibly one of the factors leading to prematurity and perinatal death was the length of the interval between the previous delivery and the subsequent conception. The young mother might not have had enough time to prepare physiologically and nutritionally for a new pregnancy.

* All but two of the subsequent deliveries were to women who were under 20 years of age when they delivered.

TABLE 3—Obstetric Outcomes by Interval from Previous Delivery to Subsequent Conception

Outcome	No.	No. of Months from Previous Delivery to Subsequent Conception: Mean	Median	Range
Perinatal death	9	12.2	14.0	3–29
Premature live birth	20	12.7	10.5	4–36
Full term live birth*	73	12.3	10.0	1–47
Total	102*	12.4	10.0	1–47

* One set of twins considered one delivery.

	Mean Square	df	F = 0.022
Among groups	1.507	2	
Within groups	67.295	99	$p > 0.5$

The number of months between the previous delivery and the subsequent conception was calculated for the subsequent deliveries. If a delivery was less than term, the approximate gestation interval was estimated from the birth weight. Contrary to expection, a one-way analysis of variance showed no statistically significant difference between the average conception intervals for the various outcome categories (Table 3).

Prenatal Care

In both index and subsequent pregnancies, a strong relationship was demonstrated between the number of prenatal visits and the outcome of the delivery; i.e., women who made fewer prenatal visits were more likely to deliver prematurely or to have their infants die in the perinatal period. This finding can be partly explained by the fact of prematurity, which reduces the number of prenatal visits a woman can make.

The mothers who had subsequent deliveries sought less

care for the subsequent than for the index pregnancy. All kept at least one clinic appointment during the index pregnancy, and the average number of appointments kept was 7.7. For the subsequent deliveries, seven (6.8 per cent) received no prenatal care, and the average number of appointments kept was 5.1. Of the nine perinatal deaths, two of the mothers had no visits, five had only one, one had three, and the visits of one were unknown. Some of the deaths might have been prevented had the mothers sought early and regular care, but this association cannot be shown to be causal.

Differences between Mothers

Were the mothers who delivered again different from those who did not in ways that may have influenced obstetric outcomes? Four categories will be analyzed: preexisting characteristics, participation in the special program, obstetric outcomes for the index pregnancy, and subsequent life status.

PREEXISTING CHARACTERISTICS

The two groups did not differ significantly on any of the following preexisting characteristics: age, race, religion, socioeconomic quartile, length of residence in New Haven, number in the household, ordinal position, birthplace, educational goals, appropriateness of grade level, number of parents in the household, welfare status, or number of previous pregnancies.

PROGRAM PARTICIPATION

Women who delivered again participated less in the special programs. For example, the mothers who later had subsequent infants attended the special educational program a lower percentage of the days for which they were eligible and participated less actively in the group sessions.

The mothers who delivered again also made fewer prenatal visits during the index pregnancy, although this did not appear to influence obstetric outcomes adversely for that pregnancy. Their average number of clinic visits during the index pregnancy was 7.7, compared to 9.1 visits for those who did not have subsequent deliveries ($t = 2.760$, $df = 178$, $p < 0.01$). This difference was partly explained by the fact that those mothers who later had subsequent children came for care about 1½ weeks later in gestation during the index pregnancy and kept a lower percentage of clinic appointments. These differences in participation during the index pregnancy may reflect subtle differences in social, psychological, and/or environmental factors which affected the outcomes of subsequent pregnancies either directly or through reduced prenatal care.

INOEX OUTCOMES

No significant difference could be found between the 79 mothers who delivered again and the 101 who did not in the obstetric results of the index pregnancy (Table 4). Nor did the two groups differ on any other index of maternal and child health during the index pregnancy. As a group, those mothers who delivered again evidently were biologically as able to produce healthy children as those who did not. The results of the subsequent deliveries, therefore, do not reflect a selection process whereby the mothers at highest risk were those who delivered again.

SUBSEQUENT LIFE STATUS

The mothers having subsequent babies differed from those who did not on a number of indicators of life status at 15 and 26 months postpartum. For example, they were less likely to be in school and to be working. However, it is difficult to interpret these data as indicating a difference between the index and subsequent mothers, because the very fact of having another pregnancy may be the explanation for less schooling and employment.

Discussion

During the past decade, special interest has been focused on the very young mother, and many programs have been established to reduce her obstetric risks. Less attention has been focused on those mothers having subsequent pregnancies, perhaps because it has been assumed that the added year or two between pregnancies reduced obstetric risk, or perhaps because program staff are not aware of the problems of these same girls as they

TABLE 4—Obstetric Outcomes of Index Pregnancy, by Subsequent Delivery

Obstetric Outcome of Index Pregnancy	Subsequent Delivery: Yes		Subsequent Delivery: No		Total	
	No	%	No	%	No	%
Stillbirth	0		0		0	
Hebdomadal death	0		2	2.0	2	1.1
Premature live birth	9	11.4	10	9.9	19	10.6
Full term live birth	70	88.6	89	88.1	159	88.3
Total	79	100.0	101	100.0	180	100.0

become older, since they are less likely to use special services. However, this study indicates that subsequent infants are at greater obstetric risk than those infants delivered previously, when the mother received special services for her initial pregnancy. More attention should be given to subsequent pregnancies among teenage girls, both from a service and a research viewpoint.

The reasons why some of these mothers had little or no prenatal care for subsequent pregnancies are not apparent. The fact that these mothers also sought less care for the index pregnancy than those mothers without subsequent pregnancies suggests that they had less understanding of the importance of obstetric care, or that something in the home situation interfered with clinic attendance.

The YMP, which assisted the young mothers to achieve good obstetric outcomes during the index pregnancy, did not appear to have helped those with subsequent pregnancies to have equally good obstetric outcomes.

The crucial questions are why, despite the special program's extensive educational effort during the index pregnancy, many did not use contraception, and why many of those who were pregnant again did not receive adequate care.

Perhaps the young mothers felt guilty about returning for care since the program personnel had expected that they could be successful contraceptors. Those encouraging the use of contraceptive methods may not have felt able at the same time to help the young mother to plan for the failure of family planning. Is it really possible to say with conviction, "You can postpone the next baby if you want to" and at the same time say, "If you do have another baby come back to see us early"? It was apparent that some of the girls felt keenly the expectation of the clinicians who gave them the contraception, because more than one stated at interviews 1 to 2 years later that they would not feel right about going back to the Young Women's Clinic with another baby.

Conclusions

During the past decade, more interest has been focused on providing care for young mothers during their first pregnancies than during subsequent ones. This study suggests that the infants at greatest risk are those delivered subsequently to girls still in their teens. Clearly, the high risk of prematurity and perinatal death provides justification for delay of subsequent infants in teenage mothers.

If subsequent pregnancies cannot be prevented, greater efforts should be made to provide care to young mothers experiencing second or third pregnancies.

A special comprehensive crisis intervention program for school-age mothers, while apparently having a positive effect on obstetric outcomes for index infants born to participants, had no long lasting impact (i.e., no beneficial effect on the outcomes of subsequent pregnancies).

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"APPENDIX B"

Induced Abortion and Sterilization Among Women Who Became Mothers as Adolescents

JAMES F. JEKEL, MD, MPH, NATALIE C. TYLER, RN, BA, AND LORRAINE V. KLERMAN, DrPH

Abstract: Four cohorts of urban women who delivered a child before reaching age 18 were followed for periods ranging from 6 to 12 years to determine use of abortion and sterilization. The two more recent cohorts had been served by comprehensive service programs. About 40 per cent of each of the groups used abortion or sterilization to control fertility. Most of the women seeking abortion had no subsequent term or near term deliveries, suggesting that such a request may signal a desire to terminate childbearing, at least for a few years. A high proportion of the young mothers obtained abortions during the second trimester, even for repeat abortions. (Am. J. Public Health 67:621–625, 1977)

To what extent do women who become mothers while of school age subsequently use surgical means to control fertility? This paper seeks to answer this question for two cohorts of young women who participated in a comprehensive service program* for school-age mothers in New Haven, Connecticut, and to compare their experience with that of two groups of similar women who delivered prior to the development of special services. This is a follow-up study of a large-scale evaluation of programs for school-age mothers published previously.[1]

Related Studies

Little is known about the use of surgical means of fertility control by young mothers served by comprehensive service programs. Some pregnant teenagers seek abortion and those who enter comprehensive service programs apparently expect to carry the present pregnancy to delivery. The literature describing such programs often emphasizes their provision of contraceptive education and devices to prevent subsequent unwanted pregnancies; abortion counselling is seldom, if ever, mentioned. Moreover, much of the literature on programs for school-age parents describes services provided in the 1960s, before abortions were widely available.

In the 1970s a limited number of follow-up studies have suggested that the subsequent fertility of mothers served by comprehensive programs, although reduced below that expected without such programs, is still high.[2–4] Although abortions have become more accessible to many school-age mothers, in 1974 there were 247,000 births to women under age 18 in the United States.[5] Recent data show that unmarried women have a much higher legal abortion ratio** than do married women, nonwhite women have a higher legal abortion ratio than white women, and women under age 15 have the highest abortion ratio of any age group, with the 15–19 year age group also being high.[6] Pregnant adolescents, who are usually unmarried when they conceive, thus combine two and often three of these characteristics, and, therefore, would be expected to be at high risk for abortion. Those who participate in comprehensive programs, however, have decided not to terminate their pregnancies and they are often given intensive education in contraceptive use after delivery. They might be expected, therefore, to seek abortions less often than would be anticipated on the basis of age, ethnic group, and marital status. Few data have been reported for this population, however. Furstenberg[7] studied long term fertility among school-

Address reprint requests to Dr. J. F. Jekel, Associate Professor of Public Health, Department of Epidemiology and Public Health, Yale University School of Medicine, 60 College Street, New Haven, CT 06510. Ms. Tyler is Research Assistant, Yale University School of Medicine; Dr. Klerman is Associate Professor of Public Health, Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University. This paper, submitted to the Journal October 26, 1976, was revised and accepted for publication March 2, 1977. An earlier version was presented at the 1975 Annual Meeting of the American Public Health Association in Chicago.

*A comprehensive service program usually offers prenatal care, counselling, and special educational opportunities. It may also provide day care, family life education, and other services.

**The legal abortion ratio is the number of legal abortions per 1,000 live births for the defined group.

age mothers in Baltimore, most of whom were non-white, and found that whereas only 1 per cent terminated their first pregnancy by abortion, 4 per cent aborted a second pregnancy, and 19 per cent and 18 per cent aborted third and fourth pregnancies, respectively. His sample included both those served by a special clinic for school-age mothers and those served only by a regular obstetrical clinic, but the data were not analyzed to determine if there was a difference between these groups.

Populations Studied

All the women studied delivered at the Yale-New Haven Hospital (YNHH) for the index pregnancy, i.e., the one that brought them into the study. Two groups were served by the Young Mothers Program (YMP), a comprehensive service program and two control groups received traditional services.[1] The first study group consisted of 180 women served by the YMP in 1967–1969, who were studied prospectively (the "Prospective" group). The second group were served by the YMP in 1965–1967, prior to the addition of the program's educational component. This group of 111 was originally studied retrospectively (the "Retrospective" group.) The third group (Control group I) consisted of 83 young women who delivered during 1963–1965, before the development of the YMP; they were otherwise similar to the two groups already mentioned. The fourth group (Control group II) included 54 young mothers who also delivered in 1963–65, but who did not meet all of the research criteria for the major study because of marriage, residence outside of New Haven, pregnancy terminated in a spontaneous or therapeutic abortion, or lack of prenatal care.

The study groups were similar in many ways: mostly poor, mostly non-white, and with a median age of 16 years.[1]

Methods

In 1975 the inpatient, outpatient, and emergency room records of the YNHH were reviewed for evidence of deliveries or other terminations of pregnancy, and for other medical and social information on all members of the four groups. The dates and methods of all terminations of pregnancy were recorded and also the date of the last visit of any kind. Some women were lost to follow-up, but a surprisingly high percentage could be followed for most of the study period (Table 1). The earlier (control) groups had a smaller percentage seen at YNHH within the last two years, but fully as high a proportion of Control group I had been followed at any point in time after the index pregnancy as was the case in the Retrospective or Prospective groups. Some of the differences seen in Control group II, however, might be due to less adequate follow-up.

Because YNHH chart numbers were available from the previous study, there was no loss to follow-up due to name changes. It is possible that some young mothers went to New York or elsewhere to obtain abortions, especially before 1973 when they became freely available in New Haven, but they could not have obtained abortions at the only other hospital in the New Haven S.M.S.A. with an obstetrical unit, the Hospital of St. Raphael. The data on surgical terminations reported here, therefore, might underestimate their use.

Use of Induced Abortion

A significant minority of all four groups used induced abortion during the follow-up period (Table 2). All but four abortions in this analysis were medically induced and legal; four mothers used self-induced abortions; there were no known illegal abortions. Because of their small number, the self-induced abortions are not separated out for separate analysis. Thirty-four per cent of the most recent group of school-age mothers had one or more abortions. The percentage is lower in the earlier groups, which may reflect the fact that abortion was not freely available in New Haven until 1973.

Except for the Control group II, none of the young mothers aborted the index pregnancy (to have done so would have made them ineligible for the study.) None were known to have given up their babies for formal adoption. The findings reported, therefore, apply to women who chose to keep an early child.

For the two most recent study groups, almost one-half of those using abortions for the first time did so to prevent or delay delivery of a second child (Table 3). Another one-third sought abortions after they had had two children, and less than one-third underwent first abortions for higher orders of parity. Those who did not seek surgical intervention until higher parities tended to use sterilization instead.

An increasing proportion of pregnancies were terminated by abortion as gravidity increased (Table 4). In this table, in order to simplify analysis and description, all known pregnancies for each young mother were counted, regardless of method of termination. The increase in the proportion aborted with increasing pregnancy number is consistent with

TABLE 1—Length of Time since Delivery and Recency of Follow-up by Group

Group	Number	Year Delivered	Potential Follow-up (yrs.)	Per Cent seen at YNHH in last 2 yrs.
Prospective	180	1967-1969	6-8	84
Retrospective	111	1965-1967	8-10	83
Control I	83	1963-1965	10-12	71
Control II	54	1963-1965	10-12	56

TABLE 2—Number and Percentage of Young Mothers Undergoing One or More Abortions, All Groups.

	Group									
	Prospective		Retrospective		Control I		Control II		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Total number	180	(100)	111	(100)	83	(100)	54	(100)	428	(100)
No. with one or more abortions	62	(34)	28	(25)	15	(18)	10	(19)	115	(27)
Of these mothers, no. with one or more known self-induced abortions	1	(1)	1	(1)	2	(2)	0	-	4	(1)

the findings of Furstenberg[7] mentioned above and may reflect an increasing concern on the part of young mothers to limit further fertility.

The significance of an abortion can be seen even more clearly by looking at the number of live infants delivered subsequent to the first use of an induced abortion (Table 5). In three of the four groups, almost 80 per cent of those undergoing induced abortions had no subsequent term or near-term deliveries during the follow-up period, even though one young mother had as many as 5 consecutive abortions over a four-year period. Only 22 per cent of the 61 young mothers in the Prospective group using induced abortion had any term deliveries subsequent to the first induced abortion, and most of these had only one subsequent delivery. In most of the young mothers, the decision to seek an abortion appeared to signal a desire to prevent having further children, at least for several years; the average period of known follow-up after the first abortion was 2.2 years for the Prospective group, 3.2 years for the Retrospective group, and 3.6 years for the Control I group.

A high proportion of the young mothers seeking abortion obtained them after the first trimester of pregnancy (48 per cent of first abortions and 37 per cent of subsequent abortions.) These proportions for late abortions are far higher than the U.S. average for 1972 (16.5 per cent) and the New York City experience during a similar time (17.7 per cent).[8] Although some of the differences may be due to the time required for psychiatric approval (needed before the Connecticut law was liberalized), some of the differences may reflect lack of education about abortion or ambivalence in the young mother toward obtaining an abortion.[9, 10]

Use of Sterilizations

The data on sterilizations for all groups give further support to the suggestion that many young mothers wanted to terminate childbearing. Surgical sterilization had been obtained by 21 women (12 per cent) of the Prospective group by an average of seven years after the index pregnancy; by 19 women (17 per cent) of the Retrospective group by an average of nine years postpartum; by 22 women (27 per cent) of the Control group I and by 14 women (26 per cent) of Control group II by an average of 11 years postpartum. The number of known sterilizations per year per 100 women varied between 1.7 and 2.5 in the four groups.

Not all of the sterilizations were done for the purpose of preventing subsequent pregnancy. Twenty-seven per cent of the sterilizations in the four groups were hysterectomies, done for a variety of reasons, including carcinomas-in-situ of the cervix, an ovarian tumor, and problems resulting from chronic pelvic inflammatory disease. However, the reasons for hysterectomies as opposed to tubal ligation were not always apparent from the hospital charts.

One woman who had undergone a bilateral tubal ligation at age 20 following two deliveries, two miscarriages, and one

TABLE 3—Parity at Time of First Induced Abortion, All Groups.

Parity at First Abortion	Group									
	Prospective		Retrospective		Control I		Control II		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
0							1	(10)	1	(1)
1	30	(48)	12	(43)	1	(7)	1	(10)	44	(38)
2	20	(32)	10	(36)	3	(20)			33	(29)
3	9	(15)	5	(18)	7	(47)	2	(20)	23	(20)
4	3	(5)	0		4	(27)	6	(60)	13	(11)
5			1	(4)					1	(1)
Total	62	(100)	28	(100)	15	(100)	10	(100)	115	(100)

TABLE 4—Number and Proportion of Pregnancies Terminated by Abortion, Prospective and Control I Groups.*

Prospective Group			
Pregnancy Number	N	No. Terminated by Induced Abortion	Percent Terminated by Induced Abortion
1	180	0**	0
2	149	29	19
3	98	21	24
4	48	14	29
5	28	11	39
6+	7	5	71

Control I Group			
Pregnancy Number	N	No. Terminated by Induced Abortion	Percent Terminated by Induced Abortion
1	83	0**	0
2	74	1	1
3	60	3	5
4	[illegible]	7	18
5	[illegible]	7	29
6+	[illegible]	6	40

*This table cannot be compared directly with Table 3 because all known pregnancies are included here (i.e. gravidity), whereas only post-20 week-gestation terminations are included in table 3 (parity).

**No abortions present for index pregnancies because criteria for admission to research groups excluded those with abortions, and most were pregnant for the first time.

induced abortion, subsequently decided she wanted more children and had surgery to reanastomose the tubes. It is not yet clear whether or not the surgery was successful. Another was considering similar surgery. The modal parity for the groups at the time of sterilization was three, with the range from one to nine. The age at sterilization among the four groups varied from 14 years (a hysterectomy done for extreme retardation and uncontrollable behavior during menses) to 28 years. The median age at sterilization in the four groups was 21, 23, 25, and 25 years. The interval from termination of first pregnancy to the time of sterilization ranged from 0 to 14 years, with the average in the four groups being 4.2, 6.4, 7.8, and 8.7 years respectively.

Relatively few women used abortions before resorting to a probably irreversible solution (Table 6). Rather, the two control groups tended to use sterilization, and those served by comprehensive programs tended to use abortion. This may be partly explained by the higher parity of the older groups. The greater number of sterilizations among the control groups may also reflect a greater desperation among a group for whom induced abortions were not easily available. The desperation of some is well shown by the experience of one woman who, following two deliveries, aborted *herself* four times, then had a medically induced abortion, and finally obtained a sterilization at age 21.

An attempt was made to find variables that would predict use of abortion or sterilization. A large amount of data on personal, educational, and medical variables were collected in the original study of the Prospective group.[1] These data were obtained in a prospective manner and therefore the only statistical biases to be expected in examining associations with later use of surgical termination of pregnancy would be due to differential loss to follow-up. Since most of the young mothers were located for interviews two years postpartum, this is not thought to be a serious problem.

Contrary to expectation, none of the many variables tested was a good predictor of whether or not the young mother would subsequently seek a surgical termination. The only statistically significant patterns which emerged were that those young women who stayed in school through graduation and/or remained single tended to use abortions more than sterilization, and those who dropped out of school and married were more likely to use sterilizations. Marital status at delivery of the index child and 26 months later did not predict use of abortion. The data on marital status thereafter were not considered reliable enough to analyze. Acceptance of contraceptives postpartum and their reported use at 26 months postpartum were *not* associated with either use of abortion or sterilization.

Discussion

This study shows that subsequent fertility looms as a serious problem to many school-age mothers, regardless of whether they participated in comprehensive service programs. Despite the fact that the data reported here are minimum estimates (since some were lost to follow-up), approximately 40 per cent of all four groups used either abortion or sterilization, or occasionally both, to control subsequent fertility.

This heavy reliance on surgical means of fertility control was not anticipated and was somewhat disappointing in view

TABLE 5—Number of Term or Near Term Deliveries *Following* the First Induced Abortion, All Groups.

Number of Deliveries after first induced abortion	GROUP									
	Prospective		Retrospective		Control I		Control II		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
0	50	(81)	15	(54)	11	(73)	8	(80)	84	(73)
1	8	(13)	12	(43)	2	(13)	1	(10)	23	(20)
2	4	(6)	1	(4)	2	(13)			7	(6)
3							1	(10)	1	(1)
Total with abortion	62	(100)	28	(100)	15	(100)	10	(100)	115	(100)

TABLE 6—Joint Distribution of Use of Sterilization and Abortion among All Groups.

	GROUP									
	Prospective		Retrospective		Control I		Control II		Total	
	N = 180		N = 111		N = 83		N = 54		N = 428	
	No.	%	No.	%	No.	%	No.	%	No.	%
No. mothers using ster. and/or abortion	78	(43)	42	(38)	31	(37)	21	(39)	172	(40)
Mothers using abortion only	57	(32)	23	(21)	9	(11)	7	(13)	96	(22)
Mothers using sterilization only	16	(9)	14	(13)	16	(19)	11	(20)	57	(13)
Mothers using abortion and sterilization	5	(3)	5	(5)	6	(7)	3	(6)	19	(4)

of the Young Mothers' Program's attempt to encourage use of contraception through counseling and education. Two possible explanations must be considered: 1) that these young mothers experienced contraceptive failure, and that surgical means of fertility control were sought to deal with this failure; or 2) that surgical procedures were used in preference to contraception as a means of controlling fertility. In this study, neither acceptance of contraceptives in the immediate postpartum period nor the reported use of contraception 15 or 26 months postpartum were associated with surgical methods of fertility control. Perhaps the decision to seek surgical intervention is a highly individual response to immediate felt needs and not due to a stylized response set.

These findings raise a number of serious questions. Why are the existing methods of contraception not adequate to meet the fertility control needs of almost one-half of this population? How can they be made more satisfactory? Should discussions of the alternatives of abortion and sterilization become a regular part of the family planning educational programs for young mothers? To do so would risk alienating religious and ethnic groups, and might also be interpreted as an endorsement or encouragement of these methods. Yet, it may be equally wrong to let a high risk population face decisions about surgical means of termination without previous discussion of the issues involved, such as the importance of seeking help early should an abortion be contemplated. Unfortunately, this study has no answers to the questions raised in this paragraph.

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"APPENDIX C"

CONNECTICUT
HEALTH
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Community Programs For Adolescent Parents And Their Babies, The Role Of The State Department Of Health

Mary R. Langton, M.A., A.C.S.W.; Marion E. Eisnor, R.N., M.A.
Medical Social Work Consultant; Public Health Nursing Consultant

In previous issues of the monthly bulletin[1] we have described the attempts of the state department of health to improve medical and social services for unmarried mothers. The program which began in 1952, in the maternal and child health section, has been known as "Coordinated Medical and Social Care for Illegitimately Pregnant Women and Their Babies Born Out of Wedlock", a title which now sounds hopelessly old fashioned. This article will describe the development of the program to meet the needs of our changing times.

In the eighteen years since the program began, there have been gradual but pronounced changes in the whole out-of-wedlock picture, not only in Connecticut, but nationwide. Although the number of babies born out of wedlock continues to increase in Connecticut (up from 4,037 in 1968 to 4,518 in 1969, a 12% rise), social and moral attitudes toward illegitimacy are in a state of transition. These attitudes vary so greatly in different socio-economic sub-cultures of our society that there is no longer agreement as to how serious a problem out-of-wedlock pregnancy is or how best to deal with the parents and their babies. When young motion picture stars freely discuss their out-of-wedlock pregnancies and proudly present their babies to society through news media, the youth of this society becomes keenly aware of our uncertain social values.

Although the state department of health has been concerned primarily in assuring good medical care and social services for unwed mothers in order to prevent health and social problems, it has inevitably also been concerned with attitudes. In order for the mothers to receive care as early as possible, efforts had to be made to influence attitudes of professionals toward the unwed pregnant girl. If these attitudes were punishing, the girl's fears would be intensified. She would retreat from using the very services set up to help her with her

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"problem". On the other hand, if attitudes were too permissive, many feared it would encourage out-of-wedlock pregnancy. Helping physicians, nurses, social workers and educators serving the girls to steer a course between these two extremes was an essential part of the program. In order to do this, the focus of the program was on the promotion of good preventive health care which would be more likely to produce a healthy baby. Early social service could enable the girl to make a healthier social adjustment herself and help her make a sound plan for her baby. In spite of the fluctuating social values, this aim has given a steady and realistic function through the eighteen years of the program.

PHASE I

From 1952 until 1966 the program developed from a limited service to three rural counties to a statewide program. In the beginning, efforts were directed toward reaching individual physicians, nurses and social workers through meeting with hospital staffs, public health nursing agencies, social service agencies, and committees from the Connecticut Medical Society. Physicians were encouraged to call upon social agencies and public health nurses to assist the girl. The agencies were encouraged to call physicians to assure early medical care and to coordinate their efforts. The development of this inter-disciplinary communication became one of the most important accomplishments of the program. At first the program staff (maternal and child health physician, medical social work consultant, and public health nursing consultant) received many calls from these professionals, asking for information about how to effect referrals. However, as communication improved, this intermediary step became less necessary.

In order to facilitate the referral process, the program made funds available to pay for the prenatal and postpartum medical care of the pregnant girl and for hospital care of the mother and baby. This financial assistance, which was provided by the U. S. Children's Bureau funds for the program, was available for girls not eligible for any type of public welfare assistance and was contingent upon the girl receiving both medical and social services. Soon the referrals to the program were coming almost entirely from social agencies. They saw to it that the girl received medical care and gave counselling to her and her family. Patients were never seen by the program staff, an arrangement which helped to strengthen the relationship between the girl and the social agency. By 1968, 191 girls a year were receiving this financial aid from the program. Most were middle-class white girls who were placing their babies for adoption. They or their families had marginal incomes. Young clerical workers who were self supporting were the largest group referred.

PHASE II

In 1964 the department began the out-of-wedlock study described in the article in the February 1970 bulletin. The following facts were highlighted by the study:

Most of the 3049 unwed mothers were very poor (over one-half were receiving public assistance).

- Sixty-five percent were keeping their babies.
- Most of those who kept their babies were Negro or Puerto Rican (90.3% of the Negro babies and 93.3% of the Puerto Rican babies went home with their mothers).
- Forty-three percent of the 635 mothers who were in school received no special schooling during pregnancy.
- Only 69% of the mothers were known to have received regular prenatal medical supervision; most did not begin regular medical care until the fifth month or later.
- Thirty-eight and five-tenths percent of the white mothers, 37.4% of the Negro mothers, and 32% of the Puerto Rican mothers were teenagers.
- Thirty-eight percent of the mothers had at least one previous out-of-wedlock pregnancy.

It became apparent even before the study was published in 1969 that the program would have to be changed in order to provide services for the majority of unwed mothers who kept their babies. The study showed that these girls did not go to social agencies other than welfare departments for financial help. This included almost all of the Negro and Puerto Rican girls.

A decision was made to gradually phase out the old program which was based on our giving financial assistance to girls referred by social agencies and to find new ways of reaching this larger group of mothers. Most of them were, by virtue of poverty and immaturity, greatly in need of help for themselves and their babies.

Through reading about programs in other states[2] and through previous experience in working with several Connecticut communities which had developed special programs for pregnant school girls[3], possibilities were seen for preventive public health work and for spending program funds and using staff time in developing community programs for teenagers having their first babies. This group seemed to offer the most favorable prognosis for rehabilitative efforts. It was also a group which could attract the most public interest and sympathy because of their youth. Interest in this group is high because they are considered high risk from a medical and social point of view. They seem to have so many needs which are best met by an inter-disciplinary, community approach. Previous program contacts with hospitals, physicians and agencies could be used to build a new type of program. In May 1968 the

program statewide advisory committee, made up of representatives of these agencies, agreed that this new focus was needed and approved and encouraged program changes to more realistically meet the needs of unwed mothers.

● **Waterbury:** In July 1968, the first opportunity came to participate in the development of what have come to be referred to as "community-based comprehensive programs for teenage parents". Through two social agencies it was learned that a committee had been meeting at the YWCA in Waterbury to develop such a program. The committee, typical of groups organized in other communities, was composed of representatives of the schools and social and health agencies concerned with unwed mothers. The staff of the state maternal and child health program was invited to meet with the Waterbury committee. After a number of planning meetings, a proposal was written requesting funds from the MCH program to provide a coordinator who would direct a project to try to reach all teenage pregnant girls. The committee was to hire the coordinator and act as the policy-making body. All the agencies agreed to make referrals to the project and to provide services. The Visiting Nurse Association agreed to provide instruction in prenatal and infant care; the two family agencies to do individual and group counselling; the Nutrition Council to give nutrition education and supervise lunch; the Board of Education to provide teachers for either homebound instruction or classes in a special school. Within six months the Board of Education had agreed to hold the special school in the YWCA where the girls had been coming for the rest of the program. The committee continued to meet to iron out problems and to plan how to meet gaps in services, e.g., infant day care. The staff of the MCH program continues to serve on the committee and to give consultation as needed. After three years of MCH stimulus for funding for the project, local funding has been obtained by the committee, thus permitting utilization of MCH funds elsewhere in the state for similar projects.

● **Stamford:** While the Waterbury project was developing, the MCH staff started working with a similar committee which had been organized in Stamford. In June 1969, MCH funds were given to the Stamford City Health Department for a coordinator. As in Waterbury, the coordinator, hired by the community committee, directs a program which includes academic instruction, health education, instruction in prenatal and child care, social service and vocational counselling. The coordinator is active in reaching out to find all teenage mothers, including school drop-outs, and to see that they receive services. The committee, including the MCH staff, meets regularly to decide on matters of policy and to find ways to meet emerging needs of the girls.

● **Meriden:** In September 1969, the MCH staff was asked by the director of the Meriden YWCA for help in planning a project for teenage parents. As a result of MCH staff consultation, a community committee was formed. After many meetings, a plan was written and a coordinator was hired with MCH funds. In

September, a program started with the active participation of the community health and social agencies and the special pupil services of the school.

- **Middletown:** A slight modification has been made for a project centering around Middletown. Here a regional approach is being tried. The MCH staff, at the invitation of one of the social agency directors, approached the Middlesex Area Interagency Council to interest them in developing a program covering the fifteen towns in the Middlesex area. The Council formed a sub-committee which wrote a proposal for MCH funding for a planner to develop a regional program. Two part-time people were employed by the Council in June 1970, to begin this task. The first girls to be brought into the program were from Long Lane School. The social work director who had formerly worked in the state department of health was eager to use the new program to help the pregnant girls at the school.

- **Norwalk:** In November 1969, the medical social work consultant of the maternal and child health section asked the executive director of the Greater Norwalk Community Council to meet with her to discuss how a program could be developed in Norwalk. The maternal and child health staff were invited to meet with the Council's Adolescent Mothers Committee which had been meeting for many months to consider how to provide improved services for these mothers. The hospital professionals, who have a special interest in adolescents, have been very active, along with the representative of the schools and local health and social agencies. A coordinator is expected to begin a program before January 1971.

- **Hartford:** In Hartford an altogether different approach has been taken. The committee which had planned for the Interagency Services for School-Age Mothers five years ago is now concerning itself with coordination of services to all unwed mothers. The MCH staff, which was active on this committee, suggested using MCH funds for a planner-coordinator who has been employed by the Greater Hartford Community Council to assure that services are improved, the gaps in services spotted, and new services developed. The planner is assisted, not only by the professional advisory committee (which includes the MCH medical social work consultant), but by a community committee of concerned citizens representing the consumers of service.

Since the Interagency Services program has now been taken under the direction of the Hartford Board of Education, MCH funds have been given to two community agencies to supplement the services of the school department. The Child and Family Services of Connecticut is providing additional follow-up services and research for evaluation. The Hartford Visiting Nurse Association is providing a special instructor from the Parents Association for Childbirth Education. She will work with the public health nurse from the VNA who is assigned full time to the school program.

Other Aspects of MCH Staff Consultation

It is needless to say that hours of valuable time have been given by the MCH staff, as well as by the local committee members, to work out sound plans which would involve all elements of the community in active participation on these new projects. As the ongoing programs grow, many unmet needs are uncovered. Additional agencies have been asked to join the committees. Physicians, especially obstetricians and pediatricians, have been kept informed by the committees, the coordinators, and the MCH staff. Services have been modified to better meet the needs of the adolescent mothers. Some hospitals have re-scheduled prenatal clinics to give special attention to these girls. Staff of city health departments, Model Cities programs and community-action agencies have been involved to assure that new programs fit into plans for overall community service development. MCH staff has met with representatives of the Department of Community Affairs, the State Department of Education (Division of Vocational Rehabilitation and Bureau of Pupil Personnel and Special Educational Services) to discuss how they could contribute to the program services. The State Welfare Department, the Department of Mental Health, and the Department of Children and Youth Services have been kept informed of the MCH staff statewide efforts in behalf of young parents. Although the MCH staff has encouraged local committees to ask consumers of services to join them, in only a few committees has this been possible as yet. However, it remains an important goal of the programs.

As local programs have developed, MCH staff consultation has been given to encourage them to expand from a narrow focus on unwed mothers to a broad one of concern for teen age parents. It is generally agreed that young married couples have as many problems as unwed mothers. Increasingly the young fathers are being brought into the programs. It has been found that the boys will come to see those who show genuine interest in the girls. They, too, need help as troubled youth and as young fathers.

Interest in follow up for the young family has increased as a result of these programs. It is apparent that often after the baby is six months or a year old, serious problems arise in areas as child care, intra-family conflicts, job training and employment. The agencies are committed to follow up services to the young parents for as long as they need help. It is hoped this investment of effort by the agencies and by the MCH staff will pay off in healthy family life.

Evaluation of the community programs has been difficult. Although the program goals have been clearly spelled out, measuring success in reaching them is a complex process. The goals of the programs are generally as follows: 1) to improve prenatal and postnatal medical care for the mother and health care for the child; 2) to enable the girls to continue or complete their schooling during pregnancy; 3) to coordinate services to the girls from various social, educational, recreational and health agencies; 4) to assure the girls return to school or to job

training or employment whenever appropriate; 5) to identify unmet needs and to plan how to meet them; 6) to assure follow-up services for as long as they are needed to strengthen the young family.

The programs so far have demonstrated that many girls want and will get the schooling they need, rather than drop out as they often did in the past. Because of the increased individual attention they receive through special services, some girls return to regular school with a better academic record than they had formerly and a more positive attitude toward education. Through prenatal and other health instruction they gain new knowledge about their bodies, so that the kind of ignorance which may have contributed to their becoming pregnant can be dispelled. They keep their medical appointments, not only because someone is checking to see that they do, but also because they understand how it will help them and their babies to be healthier. Education in child care can add a new dimension to their feelings for the importance of their new role as parents. Many girls report that for the first time they feel someone cares what happens to them. They begin to show that they, too, care about themselves and their babies' future. This growing self-esteem will, hopefully, have positive results for improved family relationships and for expanded life goals.

It seems that by reaching these young people in a time of crisis, much groundwork can be laid for future growth in mental and physical health. Although the programs cannot guarantee that the girls will not have other babies out of wedlock, their increased sense of worth and self-confidence should help some of them to avoid having another baby for whom they are not ready. It is hoped that they will learn new ways of handling their personal and social problems which will enable them to make a good social adjustment, as well as to achieve personal fulfillment.

There is no way to evaluate the long-range goal of strenghtening family life although healthy family life is thought to be one of the deterrents to out-of-wedlock pregnancy. Some evidence may show up as the babies reach school age. Hopefully, they will be healthier, happier children, with fewer emotional handicaps for learning.

Future Plans

The MCH Section of the Connecticut State Department of Health plans to continue to work with communities to develop services for and with young parents. MCH staff will remain active on the committees in the programs already funded: Hartford, Stamford, Waterbury, Norwalk, Meriden and Middlesex areas. As these programs obtain funding from other sources, hopefully after a three-year demonstration period, state MCH money will be available for new programs.

Now that all the major Connecticut cities have developed programs (Bridgeport and New Haven have well-established programs not funded by MCH), a regional approach is being considered. For example, plans are being made to work with Area Cooperative Educational Services (ACES), a regional federally-funded educational program covering sixteen towns surrounding New Haven, to develop a program in this area.

Conclusion

In the eighteen years of the program's duration, many of the barriers to education and health care for unwed mothers have been lowered. Financial assistance through medicaid is often available now. Mothers have more options in planning for themselves and for their babies' future. Nevertheless, there is still much to be done to help all young parents. Even if family planning services and abortions become more readily available, there will continue to be some out-of-wedlock births. The mothers and babies are going to need not only improved, readily accessible health, educational and social services, but new resources, such as half-way houses, where the one-parent family can live with built-in child care and other supportive services for education and training. Profitable areas of exploration may be in premarital and marital counseling for young people and education to prepare them for responsible parenthood.

Many of the areas of need lie outside of the direct influence of the state department of health as they are part of the pathology of our society. There is need for new approaches to public education, public welfare assistance, unemployment, and housing. Much more has to be done to improve family life. Education for family living in a pluralistic society is a necessity if our youth are to achieve maturity and stability.

The state department of health will continue to have a role in stimulating the development of new services and in influencing public attitudes, with the long-range goal of strengthening the capacities of young parents, both unwed and wed, to cope with the stresses of a complex, changing society, so that they can rear children who are healthy in mind and body.

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An extensive bibliography is available upon request from Maternal and Child Health Section, Connecticut State Department of Health, 79 Elm Street, Hartford 06115.

Testimony - U.S. Senate Committee

On Human Resources

June 14, 1978

Helen M. Wallace, M.D., M.P.H.
Professor and Chairman
Maternal and Child Health Program
and Family Health Program
University of California
School of Public Health, Berkeley

Pregnancy in teenagers has become a major concern in the U.S.A. today, because of the serious medical, health, social, psychological, educational, and vocational concerns both for the teenage mother and for her baby. More than 10% of all teenage women become pregnant each year – at least 1.1 million women aged 15-19 years, and 30,000 below the age of 15 years. Six hundred thousand of them terminate their pregnancies with a live baby, 370,000 have abortions, and the remaining pregnancies end in miscarriage. One third of teenage births are out of wedlock, and an additional one third of births to married teenagers are conceived before the wedding. There are numerous adverse health and social consequences affecting the adolescent parent and baby. Higher morbidity and mortality rates for the mother, the fetus, and the infant are among the consequences associated with teenage childbearing. Teenage mothers never catch up educationally or occupationally relative to their classmates. Marriages that occur soon after the child is born are highly unstable, as are many teenage marriages that occur prior to the child's birth. Nearly 4 out of 5 pregnancies to unmarried women who remain unmarried, 3 out of 5 of those who marry before the child is born, and even 1 out of 6 conceived after marriage are unintended - the adolescents who have them say they would avoid them, if they had the knowledge and means to do so. A baby born to a teenage mother is more likely to be illegitimate, born to a mother with less than a high school education, to be born to a mother who received inadequate prenatal care. Such a baby is more likely to be of low birth weight, and therefore have a greater likelihood of central nervous system damage – cerebral palsy, epilepsy, mental retardation, learning disability, etc.

In 1976, we repeated a survey of an earlier survey (in 1970) of services for and needs of pregnant teenagers in the 153 large cities (those of 100,000 population and over) in the U.S.A. Of the 125 respondent large cities, 107 reported

that they had a special program for pregnant teenagers; however, the number served was relatively small. The cities reported that while these special programs were sponsored by a number of local official and voluntary agencies, the most frequent were the local education and health departments. The most frequent sources of funds were education, welfare, and health departments. The most frequent sources of medical care for pregnant teenagers were health departments (including M & I Projects), hospitals, and private doctors; only 68 cities reported a special program of medical care for pregnant teenagers.

The most frequently provided special services for pregnant teenagers were counseling (104), special education (100), family life education (100), nutrition (99), and special health classes (97). The least frequently provided special services were treatment for alcoholism and/or drug abuse (20,21), abortion (29), juvenile delinquency(30), maternity homes (34), and for truancy (37). However, other reported inadequacies were:

Sex education - only 93 cities
Interdisciplinary staff - only 81 cities
Vocational assistance - only 76 cities
Contraception - only 63 cities
Adoption - only 54 cities
Day care of infants - only 50 cities
Special work with fathers - only 49 cities
Pregnancy testing - only 48 cities
Psychiatric service - only 42 cities

Contraceptive services were most frequently provided by Planned Parenthood or local health departments, and the cities reported restrictions on this - age, parental consent, legal fees, financial eligibility test, marriage or requiring that the teenager must have had a previous pregnancy!

2

Only 70 cities reported that abortion services were available to teenagers.

Most cities (88%) provided special education (100 cities). Eleven cities reported a waiting list, ranging 30-162 girls. The waiting period reported ranges from 2 weeks to 2 semesters of school. The frequency of special services provided by the schools was:

Family life education - 102 cities

Special health classes - 101 cities

Sex education - 96 cities

Premarital or marital counseling - 70 cities.

Most cities (106) reported the provision of nutrition service for pregnant teenagers, and the contact was most frequently nutrition education. Among the services least frequently available was special feeding in special classes, school breakfast, commodity distribution program.

Only 69 cities reported that they had a followup program for mother or baby or both.

Ninety-one cities reported that they had dropouts from their special program - 65 had more dropouts during pregnancy, and 50 after delivery. Reasons given for dropout were:

Lack of interest

Lack of day care

Medical or home problems

UNMET NEEDS

For Pregnant Teenagers

These were reported as follows:

Type	Number of Cities
Social services	66
Health education	64
Health services	41
Vocational services	26
Educational services	25
Financial assistance	15
Transportation	15
Funds in general	13
Nutrition services	12

For Infants

Type	Number of Cities
Day care	89
Health education	45
Social services	27
Health services	20
Nutrition services	10
Educational services	9
Transportation	8
Financial assistance	8

Overall, the largest needs are the following:

1. Services to Prevent Pregnancy
   - A. Strengthening family life, with assistance to families in trouble
   - B. Programs of
     - Family life education
     - Sex education
     - Family planning, contraception
   - C. Counseling services for teenagers and families
   - D. Vocational assistance
     - counseling, jobs
   - E. Recreational programs
2. Services For Teenage Pregnant Girls
   - Counseling
   - Pregnancy testing
   - Interdisciplinary educational and health programs
     - special classes
     - medical and health care
     - nutritional programs
     - social services
   - Day care
   - Vocational assistance
   - Abortion services

5

Services for and Needs of Pregnant Teenagers in Large Cities of the United States, 1976

PREGNANCY AMONG TEENAGERS is a major public health problem, with serious medical, health, educational, social, psychological, and vocational implications for the mother and baby. Toxemia and prolonged labor are more common among teenagers than among older women; infant, perinatal, and maternal mortality rates are higher; and the incidence of low birth weight is higher. Further, the risk of child abuse and suicide by teenage mothers is highest. These risks are greater for the very young teenagers and for those aged 18 and 19 years. Because a 1970 survey of 150 large American cities revealed major unmet needs in the care of pregnant teenagers (*1*), we repeated the survey in 1976 to see if progress had been made in the intervening 6 years.

Presently, there are more than 20 million females in the age group 10–19 years, the largest number ever of adolescent girls in the United States. According to one survey, more than a quarter of the young women aged 15–19 are sexually active. Overall rates of childbearing among U.S. teenagers have fallen in recent years, from a high of 97.5 births per 1,000 women 15–19 years old in 1957 to 58.7 in 1974. Because the decline in the fertility rate among older women has been greater than among teenagers, births to teenagers now account for a larger percentage of all U.S. births—in 1974, they comprised 19 percent of all births. The number of births to 10- to 19-year olds has remained approximately the same—in 1974, the number was 608,000; 12,529 were to girls under age 15, and 595,449 to girls aged 15–19 years. From 1970 to 1974, birth rates declined among all teenage nonwhites; among whites the birth rates increased for ages 14 and 15, remained the same for age 16, and declined for ages 17–19 (*2*).

The illegitimacy rate (number of births per 1,000 unmarried women) from 1960 to 1974 declined for all age groups over 20, but increased by 52 percent

Table 1. Status of response by the large cities to the questionnaire, by size of city

Size of city [1]	Number of cities	Responding cities [2]	Nonresponding cities [3]	Percent responses
1 million and more	6	6	..	100.0
750,000–999,999	4	2	2	50.0
500,000–749,999	16	15	1	93.8
350,000–499,999	14	13	1	92.9
250,000–349,999	16	15	1	93.8
175,000–249,999	19	18	1	94.7
150,000–174,999	15	11	4	73.3
125,000–149,999	25	17	8	68.0
100,000–124,999	38	28	10	73.7
Total	153	[4] 125	[5] 25	81.7

[1] 1970 population census.
[2] Covering both health and education departments.
[3] No responses or responses covering only 1 department.
[4] Includes 104 cities with responses from both the local department of health and the local department of education and 21 cities with responses from either of these departments but including consultation with the other department.
[5] Includes 15 cities from which neither department responded and 10 cities from which 1 department responded without consultation with the other department.

for those aged 15 to 19. In actual numbers, out-of-wedlock births to teenagers more than doubled, from 92,000 in 1960 to 221,400 in 1974. In 1974, there were 10,600 such births to girls under 15 and 210,800 to those aged 15 to 19 (*2*).

For wed as well as unwed teenagers who become pregnant at a very young age, the probability of poverty conditions is high; both wed and unwed girls have the common problems of incomplete education, low income status, psychological and developmental problems, excessive fertility, and probable social dependency (*3*).

Dr. Goldstein is research biostatistician and lecturer and Dr. Wallace is professor and chairman, Maternal and Child Health Program, University of California School of Public Health, Berkeley, Calif. 94270. Tearsheet requests to Dr. Wallace.

Questionnaire Survey

In 1976, a survey was made of the services for and needs of pregnant teenagers in large U.S. cities (excluding Arlington County, Va.). An 8-page questionnaire was mailed to the health officer and superintendent of schools of the 153 cities with populations of 100,000 or more, according to the 1970 census.

Table 2. Provision of special programs to pregnant teenagers and number of teenagers served, by size of city

Size of city	Number of cities responding	Special programs		Percent provided	Number of teenagers served, 1974–75				
		Provided	Not provided		Under 100	100–499	500–999	1,000 or more	Not available
1 million and more	6	6	..	100.0	..	..	1	5	..
750,000–999,999	2	2	..	100.0	..	..	2	..	..
500,000–749,999	15	14	1	93.3	2	6	3	..	1
350,000–499,999	13	13	..	100.0	2	8	1	..	2
250,000–349,999	15	14	1	93.3	2	9	..	1	2
175,000–249,999	18	17	1	94.4	5	10	..	..	2
150,000–174,999	11	7	4	63.6	2	3	..	..	2
125,000–149,999	17	9	8	52.9	4	4	..	..	1
100,000–124,999	28	25	3	89.3	14	6	..	..	5
Total	125	107	18	85.6	31	48	7	6	15

During the spring and fall of 1976, three followup questionnaires were mailed to the same officials. Responses covering both the departments of health and of education were received from 125 or 81.7 percent of the 153 cities (table 1).

Questionnaire Responses

Special programs for pregnant teenagers. Of the 125 respondent cities, 107 or 85.6 percent reported having a special program of some type for pregnant teenagers in 1976 (table 2). In general, the larger cities had higher percentages of special programs. In 1970, 111 (88.4 percent) of the 130 respondent cities reported having special programs. Despite the seriousness of the problem, the number of large cities with special programs did not increase from 1970 to 1976. Caseload data were provided by 92 cities in 1976. In general, the caseloads were relatively small; for instance, 31 cities (about one-third of the cities that provided caseload data) reported that they provided care for fewer than 100 girls a year. Only 13 cities (about one-seventh of cities reporting caseloads) indicated that they provided care for 500 girls or more a year. These data point to a need to explore the issue of expanding existing programs for pregnant teenagers.

Special programs are sponsored by many agencies, but local departments of education are by far the most frequent sponsors (table 3). The establishment of new special programs increased progressively and reached a peak from 1966 to 1970. During these years, 57 cities had established such programs.

Data were requested on the total cost of special programs and the sources of funds for the school year 1974–75. Many programs are funded by a number of sources, perhaps because the amount of financing needed would be difficult for any single agency to allot. Thus, the need for combined funding is obvious. As shown in table 3, the most frequent sources of funds are the education departments, and they may represent local, State, or Federal funds (Elementary and Secondary Education Act).

Of the 107 cities with special programs, 76 reported information on costs and on numbers of girls served during the 1974–75 school year. The reported average cost per girl that year was $546.17 for programs that were specially funded.

A special program of medical care for pregnant teenagers was reported by 68 cities; 9 cities did not respond to this question. The smaller cities were less likely to have such a program. Of the many sources of medical care for pregnant teenagers, hospitals and health departments were the most frequently re-

Table 3. Special programs for pregnant teenagers, by sponsorship, sources of funds, and sources of medical care

Sponsorship and sources	Number of cities
Sponsorship	
Official agencies:	
Education department	90
Health department	19
Maternity and Infant Care Projects	7
Welfare department	7
Model cities	1
Other official agencies	11
Voluntary agencies:	
Florence Crittenton	9
Salvation Army	7
Y.W.C.A.	4
Red Cross	2
Planned Parenthood	1
Other voluntary agencies	7
Hospitals	7
Medical schools	4
Other	1
Sources of funds	
Official agencies:	
Education department	80
Welfare department	13
Health department	11
Maternity and Infant Care Projects	3
Model cities	1
Other official agencies	[1]78
Voluntary agencies:	
Florence Crittenton	3
Salvation Army	2
Y.W.C.A.	1
Other voluntary agencies	12
United Fund	7
Other	3
Sources of medical care	
Official agencies:	
Health department	29
Maternity and Infant Care Projects	14
Welfare department	7
Education department	5
Hospitals and clinics:	
Hospitals	35
Clinics (type unspecified)	12
Prenatal clinics	9
Private physicians	25
Medical schools	11
Miscellaneous:	
Family planning	2
Planned Parenthood	1
Maternity homes	1
Well-child conference	1
U.S. Navy	1
Other	11

[1] 38 State, 22 local, 13 Federal (type not stated), 1 title 19, and 1 was the Appalachian Regional Committee.

ported, followed by private physicians and Maternity and Infant Care Projects (table 5).

As shown in table 4, the following five services were provided most frequently in the special programs for pregnant teenagers: counseling, special education, family life education, instruction in nutrition, and special health classes. Least frequently provided were treatment for alcoholism, treatment for drug abuse, abortions, services for juvenile delinquents, and maternity homes. Although contraception and sex education should be given high priority for sexually active teenagers, 10 other services (counseling, special education, family life education, nutrition, special health classes, sex education, social service, home visiting, interdisciplinary staff, and vocational assistance) were provided more frequently than contraception, and the 5 most frequently provided of these 10 services were provided more frequently than sex education.

The types of providers of medical care for pregnant teenagers are listed in the following table by medical and nonmedical categories; interestingly, the nurse midwife and the nurse practitioner are playing an increasingly important part in providing such care.

Types of providers	*Number of cities*
Medical:	
Obstetrician	79
General practitioner	51
Pediatrician	33
House staff	12
Other	6
Nonmedical:	
Nurse practitioner	20
Nurse-midwife	8
Other	5

Table 4. Content of special programs for pregnant teenagers, by size of city

Special program	*Size of city*									*Total number of programs*
	1 million and more	*750,000–999,999*	*500,000–749,999*	*400,000–499,999*	*250,000–349,999*	*175,000–249,999*	*150,000–174,999*	*125,000–149,999*	*100,000–124,999*	
Counseling	6	2	13	12	14	17	8	12	22	104
Special education	6	2	12	12	14	14	7	11	22	100
Family life education	6	2	12	13	14	16	8	10	20	100
Nutrition program	6	2	12	10	14	16	8	10	22	99
Special health classes	6	2	12	12	15	12	7	10	21	97
Sex education	6	2	10	12	15	13	8	10	19	93
Social service	6	2	13	11	14	16	4	9	16	91
Home visiting	6	2	12	10	12	13	6	7	18	86
Interdisciplinary staff	6	2	10	10	12	13	6	4	19	81
Vocational assistance	6	2	8	6	13	11	6	6	18	76
Contraception	6	2	7	9	11	5	3	7	11	63
Special medical care	6	2	6	9	7	10	1	6	11	59
Adoption	5	2	7	6	9	9	1	6	9	54
Day care of infants	2	1	7	6	6	6	3	3	10	50
Special work with fathers	4	1	9	4	7	9	2	6	6	49
Pregnancy testing	3	2	7	6	7	6	1	6	6	46
Psychiatric service	3	2	7	7	7	7	..	3	6	42
Legal advice	2	1	6	6	6	6	2	4	6	39
Truancy	2	1	7	4	3	7	2	5	6	37
Maternity homes	4	1	4	6	5	5	1	4	4	34
Juvenile delinquency	..	1	6	3	3	6	1	6	5	30
Abortion	2	..	4	4	6	4	1	4	5	29
Treatment for drug abuse	..	2	4	3	2	1	..	4	5	21
Treatment for alcoholism	..	2	4	2	3	1	..	3	5	20
Number of cities responding	6	2	15	13	15	18	11	17	26	125

Hospitals and private physicians' offices were reported as the places where pregnant teenagers most frequently receive medical care (table 5). Most of the cities reported that teenagers are now being delivered in hospitals. None of the cities reported that maternity homes are still being used for deliveries. The hospitals used are frequently those administered by city or county government and are tax supported. Provision of pregnancy testing was reported by 87 percent of the cities, most frequently by health departments and Planned Parenthood (table 5). Concerning the places providing care for infants (table 5), as found in the 1970 survey (*1*), Maternal and Infant Care and Children and Youth Projects are playing a small role in providing medical care for infants.

Table 5. Places providing medical care for pregnant teenagers, pregnancy testing, and medical care for infants

Place	Number of cities
Care for pregnant teenagers	
Hospitals	54
Private physicians	44
Clinics	32
Health department	23
Maternity and Infant Care Projects	10
Medical schools	10
Education department	6
Other	11
Pregnancy testing	
Health department	57
Planned Parenthood	49
Clinics	26
Hospitals	12
Family planning	10
Private physicians	10
Maternity and Infant Care Projects	7
Medical schools	6
Welfare department	3
Model cities	2
Other	21
Care for infants	
Official agencies:	
Health department	27
Well-child conferences	19
Maternity and Infant Care Projects	7
Children and Youth Projects	4
Model cities	1
Other official agencies	4
Hospitals	48
Private physicians	45
Clinics	25
Private pediatricians	7
Medical schools	6
Other	3

Contraception. A total of 109 cities reported that they provided contraceptive services for teenagers. Generally, the smaller the cities, the less likely that such services are available.

Planned Parenthood and health departments were the most frequently mentioned providers of contraceptive services to teenagers, as shown in the following table:

Agency providing contraceptive services to teenagers	Number of cities
Planned Parenthood	64
Health department	61
Private physicians	19
Family planning	16
Clinics	16
Hospitals	11
Medical schools	5
Maternity and Infant Care Projects	4
Other	11

The cities reported certain restrictions on contraceptive services to teenagers; 21 cities have an age restriction, 21 require parental consent, 12 have legal restrictions, 8 require payment of a fee, 5 require a financial eligibility test, 4 provide the services only to married teenagers, and 2 provide the services only to teenagers who have had a previous pregnancy.

Abortion. Some 70 percent of the cities reported that abortion services are available to teenagers. In general, the smaller the city, the greater the likelihood that abortion services are not available to teenagers. The most frequent restrictions on abortion services reported are the length of gestation, 48 cities; legal, 27 cities; and parental consent, 16 cities.

Special education. Most of the cities (88.0 percent) provided special education, most frequently in a special school (94 cities). Eleven cities reported having a waiting list, ranging from 50 to 162 girls. This is more obvious in the largest cities. The waiting period reported ranges from 2 weeks to two semesters of school. Most cities reported the inclusion of family life education, 102 cities; provision of special health classes, 101 cities; 96 cities reported provision of sex education; and 70 cities reported provision of premarital or marital counseling. The larger the city, the more likely it is to provide such counseling.

Social service. Most cities reported the availability of social service. It is less likely to be available in the smaller cities. As shown in the following table, the most frequent sources of social service are the welfare departments, voluntary agencies, and health departments.

35-454 O - 79 - 44

Sources of special service	Number of cities
Welfare department	65
Voluntary agency	33
Education department	32
Health department	15
Hospitals	8
Maternity and Infant Care Projects	8
Adolescent clinics	5
Protective services	2
Other	22

Services available more frequently include counseling, adoption, foster home service, and financial support. Those services least available are housing, day care, transportation, help for the father, and clothing.

Nutrition. About 85 percent (106) of the cities reported the provision of nutrition service for pregnant teenagers. In general, the larger the city, the more likely the service is available. The content of these services most frequently consists of nutrition education. Services least frequently available are special feeding in special classes or maternity homes, commodity distribution program, and special school breakfast.

Followup services. Of the 107 cities that had a special program, 69 or 64.5 percent had followup services—58 cities reported that their program covered followup for both mother and infant; 10 cities, the mother only; and 1 city, the infant only. The followup duration was a year or less for both mother and infant, and the services were mainly medical and social.

Dropouts. For the 91 cities reporting dropouts from the special program, 65 cities reported that more dropouts occurred during pregnancy, and 50 cities reported that more occurred after delivery. The reasons given by the teenagers for such dropouts most frequently were "lack of interest," "lack of day care," and "medical or home problems."

Child abuse and neglect. Of the 125 responding cities, only 17 viewed child abuse and neglect as a problem.

Unmet needs of pregnant teenagers. The numbers of unmet needs reported by the large cities for pregnant teenagers are shown in table 6. All but 10 of the 125 responding cities reported at least 1 unmet need; the most frequently reported need was for social service. Social service includes outreach, support services, psychological and emotional support,

Table 6. Number of unmet needs reported by large cities for teenage pregnant girls and for their infants, by type of unmet need

Type of unmet need	Number of unmet needs reported: For teenage pregnant girls	For infants
Social services	66	27
Health education	64	45
Health services	41	20
General and administrative services	28	8
Vocational services	26	..
Educational services	25	9
Financial assistance	15	5
Transportation	15	8
Funds in general	13	3
Nutrition services	12	10
Day care	..	89

foster care, special group homes, education for putative fathers, rape counseling, legal services for minors, child abuse program, emergency housing, making the mother aware of community resources, crisis intervention, marriage couseling, and adoption services.

The second most frequent need reported is for health education. This includes family life education, sex education, parenting classes, contraception counseling, and making the teenager aware of community resources.

The third most frequent need reported is for health services. This includes the need for early medical care, second-trimester abortions, the availability of abortions without parental consent, additional preventive care, availability of pregnancy testing, additional multidisciplinary centers for early prenatal care, dental care, and family planning.

The fourth most frequent need is for general and administrative services, which include expansion of the program for pregnant teenagers and for followup as well as an expanded program for fathers, better coordination between the education and health departments, more staff, and easing of "red tape" in services and care.

The need for vocational services consists of assistance in providing jobs, job training and counseling, and work-oriented education. The need for educational services includes continuing education during and after pregnancy, programs for those teenagers not interested in academic programs, home tutoring, special education for the retarded, teen-parent centers, and life sciences courses.

The need for financial assistance consists of supplemental income for the mother, funding for health care, more adequate aid to dependent children (ADC) grants, and more facilities to furnish free delivery services.

The need for transportation consists of finding ways to take the mother to and from the school and the program.

The need for more funds in general consists of more adequate funding for this program and for a comprehensive care program for all pregnant teenagers.

The need for nutrition services consists of nutrition education, of a more adequate diet for the teenager, and of food supplements.

Unmet needs of infants. All but 22 of the 125 responding cities reported at least 1 unmet need for infants (table 6). The most frequent unmet need reported was day care, including more facilities, funds, staff, and additional day care centers with medical facilities. Day care includes infant and child care services in both community and school, availability of baby sitters, and coordination of special programs for the mothers with day care resources.

The second most frequent need is for health education for the mother in the care of her baby concerning infant participation in infant stimulation, early childhood education, and long-term followup of the child.

The third most frequent need is for social service, which includes training the mother for the role of parent, child abuse and neglect counseling, more growth and development programs, and identification of preschoolers who may develop learning problems.

The fourth most frequent need is for health services. This includes the need for better and less expensive prenatal care, more resources for "sick" as opposed to "well-child" care, more preventive care, greater accessibility to well-baby clinics, and additional public health nursing resources.

The need for nutrition services includes more nutrition programs, food for infants, and training of mothers in the proper feeding of their infants. Education services include training mothers in child care. Transportation services are needed for the mother and her infant to ease their travel to and from the various services. Clothing and furniture, such as cribs, are needed for infants. General and administrative services are needed to permit followup of infants, with free exchange of information about them and their records among cooperating programs.

Comparison of 1970 and 1976 Data

A comparison of the findings of the 1970 and 1976 surveys revealed that significant changes occurred with respect to the services for and needs of pregnant teenagers in the large cities (table 7).

None of the respondent cities in 1976 reported that maternity homes sponsor special programs, nor do they provide medical care for pregnant teenagers. In 1976, more cities were including family life education, nutrition programs, and day care for infants in their special programs than in 1970.

The pediatrician's role as a provider of medical care for the pregnant teenager decreased and the general practitioner's role increased. The well-child conference declined markedly as a source of medical care for infants and children. On the other hand, the number of cities reporting health departments and hospitals as sources of such care increased significantly in 1976.

Pregnancy testing increased markedly, particularly by Planned Parenthood and health departments. The number of cities that provide contraceptive services to teenagers increased by almost 50 percent; again, Planned Parenthood and health departments are the major providers of these services. During the years between the surveys, the number of restrictions on provision of contraceptive services to teenagers decreased—particularly the restrictions concerned with parental consent, marital status of the teenager, and history of previous pregnancy.

When pregnancy has not been prevented and is unwanted, the backup of abortion services is necessary. The percentage of cities that provided abortion services for pregnant teenagers rose significantly in 1976 compared to 1970. The greater availability of pregnancy testing obviously makes it possible to use abortion services in the first trimester with much less risk to the teenager. A marked change occurred in the kinds of legal restrictions on abortion services by 1976. In 1970, 73 cities had legal restrictions, and in 28 cities length of gestation was a restriction; however, in 1976 only 27 cities had legal restrictions, but 48 cities had the restriction of length of gestation. Thus, the restriction of length of gestation increased while legal restrictions markedly decreased. It seems that a greater concern for the health of the mother is reflected in these changes.

The existence of waiting lists for admission of pregnant teenagers to programs of special education is decreasing. Special education programs in a greater number of cities include family life education, sex education, and special health classes. Also, a greater

Table 7. Statistically significant differences between results of 1970 and 1976 studies of services and needs of teenage pregnant girls in large cities of the United States

Item compared	Percent of cities				
	1970	1976	Difference	Chi-square	P
Special program sponsored by maternity homes	15.4	0	−15.4	18.80	< .001
Ability to provide cost of care information	42.5	71.0	28.5	17.07	< .001
Provision of family life education in special program	68.5	80.0	11.5	3.84	< .05
Provision of nutrition program in special program	65.3	79.2	13.8	5.39	< .05
Provision of day care for infants in special program	25.4	40.0	14.6	5.55	< .05
Pediatrician as provider of medical care	42.3	26.4	−15.9	5.45	< .05
General practitioner as provider of medical care in special program	23.8	40.8	17.0	7.64	< .01
Maternity homes as place where medical care is provided	5.4	0	− 5.4	5.05	< .05
Well-child conference as source of medical care for infants	46.9	15.2	−31.7	28.33	< .001
Health department as source of medical care for infants	10.0	21.6	11.6	5.64	< .05
Hospitals as source of medical care for infants	9.2	20.0	10.8	5.12	< .05
Provision of pregnancy testing	60.0	87.2	27.2	22.74	< .001
Pregnancy testing by health department	26.9	45.6	18.7	8.85	< .01
Pregnancy testing by Planned Parenthood	14.6	39.2	24.6	18.46	< .001
Provision of contraception	59.2	87.2	28.0	23.88	< .001
Provision of contraception by Planned Parenthood	32.3	51.2	18.9	8.60	< .01
Provision of contraception by health department	23.0	48.8	25.7	17.27	< .001
Parental consent as a restriction on provision of contraception	43.8	16.8	−27.0	20.70	< .001
Marital status as a restriction on provision of contraception	10.8	3.2	− 7.6	4.47	< .05
Prior pregnancy as a restriction on provision of contraception	13.5	1.8	−12.2	11.58	< .001
Provision of abortion services	18.9	70.4	53.5	72.13	< .001
Legal restriction on provision of abortion services	56.2	21.6	−34.6	30.49	< .001
Length of gestation as a restriction on provision of abortion services	21.5	38.4	16.9	7.87	< .01
Existence of waiting list for special education	26.2	8.8	−17.4	12.04	< .001
Provision of family life education in special education	70.0	81.6	11.6	4.05	< .05
Provision of sex education in special education	61.5	76.8	15.3	6.25	< .05
Provision of special health classes in special education	69.2	80.8	11.6	3.94	< .05
Provision of social services by welfare department	28.5	52.0	23.5	13.75	< .001
Provision of special nutrition program	58.5	64.5	16.3	8.57	< .01
Provision of nutrition education in special nutrition program	63.8	81.6	17.8	9.21	< .01
Provision of extra foods in special nutrition program	36.2	51.2	15.0	5.27	< .05
Provision of special school breakfast in special nutrition program	11.5	25.6	14.1	7.47	< .01
Provision of special school lunch in special nutrition program	37.7	51.2	13.5	4.15	< .05
Educational services as unmet need for pregnant teenagers	79.2	20.0	−59.2	87.08	< .001
General and administrative services as unmet need for pregnant teenagers	73.1	22.4	−50.7	63.53	< .001
Health services as unmet need for pregnant teenagers	58.5	32.8	−25.7	15.68	< .001
Financial assistance as unmet need for pregnant teenagers	36.2	12.0	−24.2	16.91	< .001
Health education as unmet need for pregnant teenagers	0	51.2	51.2	66.16	< .001
General and administrative services as unmet need for infants	15.4	6.4	− 9.0	4.38	< .05
Health services as unmet need for infants	36.2	16.0	−20.2	12.34	< .001
Health education as unmet need for infants	1.5	36.0	34.5	48.07	< .001

number of cities reported that welfare departments are offering social services to pregnant teenagers.

More cities were offering special nutrition programs to pregnant teenagers in 1976 than in 1970, and more cities with such programs were including extra foods, special school breakfasts, and special school lunches.

The 1976 survey showed marked reductions in certain unmet needs compared to the 1970 survey. In 1976, educational services, general and administrative services, health services, and financial assistance decreased significantly as unmet needs for pregnant teenagers. However, the number of cities that reported health education for the mother as an unmet need increased significantly. Although significant decreases occurred in the reported unmet needs of infants for general and administrative services and health services, the unmet needs for health education services for mothers to help them care for their infants increased markedly.

Discussion

From 1970 to 1974, in the United States there was a drop of 7.4 percent in live births to mothers under age 20 (from 656,460 to 607,978). However, the decrease in live births to mothers in this age group in the 153 large cities during the same period was almost twice as great, 13.5 percent (from 217,228 in 1970 to 187,900 in 1974). These figures indicate that —despite an increased number of females in that age group from 1970 to 1974 and an increase in sexual activity (2)—the number of births and the rates for these teenagers have dropped significantly. In the large cities, the live births to teenagers constituted 33.1 percent of all live births to this age group in 1970 and 30.9 percent in 1974.

The 92 cities that reported the number of pregnant teenagers in special programs in 1974 served a total of 29,023 girls. But the same cities reported 141,255 live births to teenagers in 1974, according to R. L. Heuser, Chief of the Natality Statistics Branch, National Center for Health Statistics. This means that only 20.5 percent or 1 in 5 of all pregnant teenagers needing special programs were accommodated. Thus, more efforts are needed in outreach, health education, special programs, and provision of facilities to care for pregnant teenagers.

Major changes occurred in services for pregnant teenagers in the large cities between 1970 and 1976. Among these changes, there were both significant increases and decreases.

Increases. In 1976 more of the large cities reported that pregnancy testing and contraceptive and abortion services were available to teenagers. This is evidence of society's movement, in general, toward liberalization of the abortion laws and of making pregnancy testing and contraception available to all women in the United States. Teenagers have benefited from this general pattern. At the same time, the welfare departments of almost twice as many cities were providing social service assistance in 1976 as in 1970. The need for health education or at least recognition of the need, for teenagers increased greatly from 1970 to 1976; this applies both to the mother herself and to the care of her baby.

Decreases. Fewer of the large cities reported constraints in making contraceptive services available to teenagers, particularly the requirement of parental consent or a prior pregnancy. Also, fewer cities reported having legal restrictions regarding abortion. The role of the maternity home has declined (4). Fewer cities reported having a waiting list for special education; this is surprising since relatively small numbers of girls were reported as receiving this service. Fewer cities reported as unmet needs such services as education, health, financial assistance, and general and administrative services. Since the roles of the well-child conference and of the pediatrician have declined, the question arises as to what kinds of services, if any, have replaced them.

Conclusions

Although the 1976 survey revealed that progress has been made since 1970 in the provision of services to pregnant teenagers and their babies, serious unmet needs still remain. These needs include social and health services and health education for the mother herself and day care and health and social services for the infant. Because teenage pregnancy is a major public health problem in the United States, much more attention and public support are strongly indicated.

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WILLIAM S. COHEN
2d District, Maine

413 Cannon House Office Building
Washington, D.C. 20515
(202) 225-6306

COMMITTEES:
JUDICIARY
SMALL BUSINESS
AGING

DISTRICT OFFICES
Federal Building
Bangor, Maine 04401
(207) 947-6936

Professional Mall
696 Lisbon Street
Lewiston, Maine 04240
(207) 784-6969

523 Main Street
Presque Isle, Maine 04769
(207) 764-3290

Congress of the United States
House of Representatives
Washington, D.C. 20515

June 9, 1978

Senator Harrison Williams
Chairman, Senate Human Resources Committee
4230 Dirksen Office Building

Senator Williams:

The upcoming Senate Human Resources Committee hearings on Adolescent Pregnancy are of great interest to me.

I would appreciate the incorporation of the attached statement to the Committee's hearing records.

With my best wishes in your Committee hearings, I am,

Sincerely,

William S. Cohen
Member of Congress

WSC/ch

STATEMENT BY:
HONORABLE WILLIAM S. COHEN

BEFORE THE:
SENATE HUMAN RESOURCES COMMITTEE

ADOLESCENT PREGNANCY

JUNE 14, 1978

SENATOR WILLIAMS AND MEMBERS OF THE SENATE HUMAN RESOURCES COMMITTEE, AS YOU EMBARK UPON HEARINGS RELATING TO THE GROWING PROBLEM OF ADOLESCENT PREGNANCY, I TAKE THIS OPPORTUNITY TO CONVEY TO YOU MY CONTINUED CONCERN OVER THIS ISSUE.

MY ACTIVE INVOLVEMENT WITH THE PROBLEM OF ADOLESCENT PREGNANCY BEGAN IN 1975, WHEN I WORKED WITH SENATOR KENNEDY IN DRAFTING LEGISLATION TO REDUCE THE ADVERSITIES ASSOCIATED WITH THE ESCALATING NUMBER OF ADOLESCENT PREGNANCIES. THE EVIDENCE DOCUMENTING THE NEED FOR SUCH LEGISLATION IS STARTLING. EVERY YEAR, ONE OUT OF EVERY TEN TEENAGE GIRLS IN AMERICA BECOMES PREGNANT, A HIGHER RATE THAN THAT IN 18 OTHER DEVELOPED COUNTRIES. ALMOST ONE-THIRD OF THESE PREGNANCIES INVOLVED GIRLS GIVING BIRTH OUT OF WEDLOCK, WITH 87% ELECTING TO KEEP THEIR BABIES. TEENAGE SEXUAL ACTIVITY IS INCREASING; MORE BABIES ARE BEING BORN TO YOUNG MOTHERS; YOUNG WOMEN OVERALL HAVE ACCOUNTED FOR A LARGER PROPORTION OF ALL BIRTHS. AT THE SAME TIME, THE NUMBER OF ADOLESCENTS VISITING CLINICS OR PRIVATE PHYSICIANS FOR PREGNANCY PREVENTION AND PREGNANCY-RELATED SERVICES REPRESENTS ONLY A SMALL PROPORTION OF THOSE IN ACTUAL NEED OF SUCH SERVICES. IN 1975, 1.6 MILLION SEXUALLY ACTIVE TEENAGERS FAILED TO VISIT A CLINIC OR PRIVATE PHYSICIAN FOR MEDICAL OR COUNSELING SERVICES. IN MY STATE, 20,000 FEMALES BETWEEN THE AGES OF 15 AND 19, NOT BEING SERVED BY ANY ORGANIZED PROGRAMS, RUN THE RISK OF AN UNINTENDED PREGNANCY.

UNWANTED AND UNEXPECTED PREGNANCIES UNDERMINE THE ABILITY OF YOUNG MOTHERS TO LEAD FULL AND PRODUCTIVE LIVES. EMPIRICAL STUDIES INDICATE THAT THE HIGH INCIDENCE OF PREGNANCY AMONG THIS AGE GROUP IS DUE TO THE IGNORANCE OF PREGNANCY RELATED INFORMATION. I BELIEVE, THEREFORE, THAT SOLUTIONS TO THESE PROBLEMS ARE AVAILABLE AND THAT WITH PROPER SUPPORT WE CAN DEAL EFFECTIVELY WITH ADOLESCENT PREGNANCY. AN AUTHORIZATION OF $60 MILLION FOR THIS PURPOSE HAS BEEN REQUESTED BY THE PRESIDENT IN THE FY 1979 BUDGET. RECENTLY, LEGISLATION WAS INTRODUCED IN BOTH CHAMBERS THAT WOULD FULFILL THIS BUDGET COMMITTMENT. THE LEGISLATION WOULD ACHIEVE OUR OVERALL OBJECTIVE BY ENCOURAGING THE PROVISION AND COORDINATION OF COMPREHENSIVE HEALTH EDUCATION, MEDICAL, PSYCHOLOGICAL, AND OTHER SOCIAL SERVICES TO ADOLESCENT PARENTS AND THEIR CHILDREN. SUCH A PROGRAM WOULD NOT ONLY BENEFIT THE YOUNG MOTHER AND THE FAMILY, BUT THE ENTIRE COHORT OF INDIVIDUALS BORN TO THESE YOUNG MOTHERS.

I WOULD LIKE TO CALL YOUR ATTENTION TO THE BILLS PRESENTLY UNDER CONSIDERATION, S. 2910 AND H.R. 12146, WHICH PROVIDE FOR IMPROVED COORDINATION OF FEDERAL AND STATE PROGRAMS. FOR THE MOST PART, THESE BILLS ARE IDENTICAL. BOTH PROVIDE FOR GRANTS WHICH "PLAN FOR THE ADMINISTRATION AND COORDINATION OF PREGNANCY PREVENTION AND PREGNANCY-RELATED SERVICES FOR ADOLESCENTS." NEVERTHELESS, I WOULD LIKE TO INDICATE MY SUPPORT FOR TWO MODIFICATIONS MADE TO THE SENATE VERSION OF THE BILL, S. 2910, SEC. 104(A) REQUIREMENTS FOR GRANT APPROVAL.

THE FIRST REQUIRES THAT THERE BE ASSURANCES THAT THE APPLICANT FOR A GRANT MAKE EVERY REASONALBE EFFORT TO COLLECT REIMBURSEMENTS FOR ITS COSTS IN PROVIDING SERVICES TO PERSONS WHO ARE ENTITLED TO PAYMENTS FOR SUCH SERVICES UNDER A FEDERAL, OTHER GOVERNMENT, OR PRIVATE INSURANCE PROGRAM. AS A MEMBER OF THE HOUSE SELECT COMMITTEE ON AGING, I AM COGNIZANT OF THE DUPLICATION AND

FRAGMENTATION AMONG FEDERAL PROGRAMS. I BELIEVE SUCH A REQUIREMENT IS CRUCIAL IF WE EVER HOPE TO CURB WASTEFUL SPENDING AND RATIONALIZE OUR SERVICE DELIVERY SYSTEM. THE STIPULATIONS UNDER SEC. 104(A) ATTEMPT TO AVERT A DUPLICATION IN SPENDING AND I SUPPORT THIS WHOLEHEARTEDLY.

THE SAME SECTION OF THE SENATE BILL ALSO REQUIRES THAT GRANTEES PROVIDE ASSURANCES THAT ACCEPTANCES OF FAMILY PLANNING SERVICES OR POPULATION GROWTH INFORMATION (INCLUDING EDUCATIONAL MATERIALS) PROVIDED UNDER THIS ACT BY AN INDIVIDUAL BE VOLUNTARY AND NOT A PREREQUISITE TO ELIGIBILITY OR RECEIPT OF OTHER SERVICES PROVIDED THE GRANT APPLICANT. THIS, IN TURN, WOULD ENABLE THE ADOLESCENT TO RETAIN THE RIGHT OF PERSONAL CHOICE IN THE MATTER AND STILL QUALIFY FOR THE FEDERALLY SPONSORED PROGRAM AUTHORIZED BY THIS LEGISLATION.

I INTEND TO JOIN WITH HEW AND OTHER CONCERNED MEMBERS OF CONGRESS IN THE DEVELOPMENT OF AN EFFECTIVE AND WORKABLE PROGRAM, AND I SOLICIT THE SUPPORT OF THIS COMMITTEE FOR SUCH LEGISLATION, WHICH THE HOUSE WILL BE CONSIDERING LATER THIS SUMMER.

THANK YOU FOR ALLOWING ME TO SHARE MY INTEREST IN YOUR DELIBERATIONS.

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TESTIMONY ON SENATE BILL 2910
SUBMITTED BY N.J. DEPARTMENT OF HEALTH
JULY 12, 1978
BY LEAH Z. ZISKIN, M.D., M.S.
ACTING DEPUTY COMMISSIONER OF HEALTH

The New Jersey State Department of Health compliments and thanks Senators Williams, Kennedy, Javits and Hathaway for sponsoring Senate Bill 2910, to establish a program for developing networks of community-based services to prevent adolescent pregnancies and to aid those who do become pregnant. The need for such a program in New Jersey is demonstrated by the following statistics:

1. During 1976, there were 90,549 births to residents, an estimated birth rate of 12.2 per 1000 persons.

2. Of these 90,549 births, 12,167 births were to teenaged mothers (19 years of age and younger). This represents thirteen per cent of the total births in New Jersey.

3. In 1976, 17 per cent of the total number of births were classified as illegitimate, while 58 per cent of the number of births to teenaged mothers were so classified.

4. Teenaged mothers gave birth to 1,442 babies of low birth weight (12 per cent of the number of births to teenaged mothers). This is a higher percentage of low birth weight infants born than to any other "age group".

5. There were 3,295 abortions performed on New Jersey residents in 1976 on women 19 years of age and younger in hospitals and licensed clinics. This is 24 per cent of the number reported to the Health Department and does not include abortions performed in private physicians' offices.

These statistics have remained fairly constant over the past several years. We are however increasingly concerned that there will not be a decrease in the number of teenage mothers, but that the statistics will become more alarming in the months to come. The unavailability and inaccessability of abortion services will be one factor which will contribute to this. Continuing federal and state court battles over the use of Medicaid funds to pay for medically necessary abortions have faced low-income teenagers in New Jersey with a dilemma. Licensed and safe facilities in which pregnancy termination can occur are being denied them because they lack the means to pay. Another factor which we believe will contribute to a rise in teenage pregnancies is the dissolution of the extended family. Maternal and Child Health Programs, Medicaid, and welfare

programs provide reimbursement for medical services and basic needs of living, but do not reimburse for ancillary services so important in influencing a young woman's feelings about herself and present or future children.

We see Senate Bill 2910 enabling projects to develop which can prevent first pregnancies or repeat pregnancies, or provide a young mother resources which will help her to care for herself and her child in a healthy and mature manner. At the present time, family planning and maternal and child health program funds are usually used for the provision of categorical services such as to provide contraceptive information and contraceptives, or prenatal, intrapartum and postpartum care to mothers and neonatal care to newborns. These very necessary and vital funds generally do not "stretch" to cover the ancillary services that adolescent parents need, namely: courses in parenting (how to function as a parent) and homemaking, or day care for their offspring, or vocational guidance for themselves.

We are highly supportive of courses for young women before, during and after their pregnancies, which will improve their self-images and increase self-respect, for themselves and for their bodies. It is extremely rare to find agencies that have sufficient funds to be able to have staff to give their young clients this broad type of comprehensive approach which we endorse.

We would like to address some specifics in the construction of Senate Bill 2910. In our experience in New Jersey, programs whose primary purpose is to provide linkages among existing services or larger categorical programs need trained and dedicated staff. To accomplish the linkages is a more time-consuming task than one would anticipate. We think this is because existing services and programs are established to offer categorical services in agencies geared to providing a single service. Examples of this are schools which educate and do not provide medical care; family planning agencies which give information and treatment and counseling about birth control but not about parenting or homemaking or day care.

To understand what each client or participant in a program for adolescents needs, the assigned personnel should function on a one-to-one basis and guide the adolescent to and arrange for all the parts of her individual program of services. In some locales, the services and funds to reimburse for the services are available and new funds are unnecessary for the actual provision of service. The personnel necessary to effect the linkage, however, is very essential. If the funds available for these salaries are calculated as a percentage of funds used to provide service, this may be insufficient. Thus, we see a disadvantage if the amount of funds allowable for administrative

or staff costs are a percentage of overall grant funds or a ratio of the funds available to reimburse for service.

We also envision disadvantages if funds from this Bill are granted directly from the federal government to local projects without including a distinct role for states. In our experience in New Jersey, programs funded directly do not become as integrated or interwoven with other community programs as one would hope. Staff is unlikely to be shared and records and reports are kept separately. Each program requires its individual unique set of reports and has its unique set of audit or review teams. By including a state agency as an umbrella or pass-through agency for these funds, local projects already providing some of the pieces needed in this linkage program may be more likely to seek consultation from the State and integrate the pieces with programs presently using the State as an umbrella agency. Examples of this are family planning programs, prenatal services funded by Maternal and Child Health funds and the WIC Programs which offers nutritional food supplements to pregnant women, infants and children.

State input into the selection of sites for projects of the type proposed by this Bill will give the federal government better insurance that the projects will be in locales where they can function well and flourish. States as keepers of health needs indicators know best where the concentrations of teenage pregnancies occur. The states know where the family planning services and prenatal programs are working independently. Having funds available through this Bill to effect closer ties will strengthen not only services to participants, but will also make federal funds presently going to support categorical projects more meaningful. For example, we think that Maternal and Infant Care Projects, where comprehensive services to pregnant women are offered, are good locus for expanded services to pregnant adolescents. To carry through on this concept in communities where Maternity and Infant Care Projects are not feasible, funds to effect linkages of the types described by this Bill are a reasonable alternative.

In summary, the New Jersey State Department of Health supports the cause which Senate Bill 2910 proposes to aid, and also the concepts which it advocates, namely, providing a comprehensive array of services to teenagers, especially the counseling to improve the young person's self-image and how to manage oneself in the real world.

The Bill, however, has structural weaknesses; these are:

That the funds to provide the linkages between the services are a percentage of the funds to provide service.

That the funds will be awarded in grant-in-aid contracts directly to local projects with no distinct and essential role for the states.

We would like to see Senate Bill 2910 amended so that funds could be provided for linkages and services in the proportions needed by the community. We would like to see the funds appropriated for the purpose of this Bill go through State Departments of Health so that the resources could be made available where they are most needed and where they would strengthen or link the existing services in some locales, and provide "missing pieces" of service in other communities.

Thank you for this opportunity to present our views on Senate Bill 2910.

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GOVERNOR'S COMMISSION ON CHILDREN & YOUTH
1100 NORTH EUTAW STREET
BALTIMORE, MARYLAND 21201
(301) 383-3700

STATE OF MARYLAND
MARVIN MANDEL
Governor
RICHARD A. BATTERTON
Secretary

MRS. G. LUTHER WASHINGTON
Chairman
HENRI ANN DANIELS
Executive Director

TESTIMONY OF MARYLAND'S
GOVERNOR'S COMMISSION ON CHILDREN AND YOUTH
BEFORE
THE SENATE RESOURCES COMMITTEE

My name is Vivian E. Washington, and I am the Chairperson of Maryland's Governor's Commission on Children and Youth. I wish to thank the Senate Resources Committee for giving me this opportunity to submit this written testimony.

Maryland's Governor's Commission on Children and Youth wishes to go on record as supporting SB 2910 - "Adolescent Health Services and Pregnancy Prevention and Care Act of 1978."

The Maryland Governor's Commission on Children and Youth was created by Executive Order in 1972 to act as an advocate for children and youth. The Commission is composed of 32 members including 10 youth representatives who are appointed directly by the Governor.

Since October, 1975, a sub-committee of the Commission has had as its focus School-Age Parents. In 1975 in the State of Maryland, there were 10,062 births out of wedlock. Of this number, 5,093 were born to mothers 19 years of age and under, and 2,740 were born to mothers 17 years of age and under.

In Maryland, the Commission working with the Maryland Congress of PTA, the March of Dimes, the Department of Education, and other concerned groups is working toward improving services on a comprehensive basis for adolescent parents. Emphasis has been placed upon education for parenting in the schools

as a way of helping young people become aware of the responsibilities of parenting before assuming this role at too early an age.

Comprehensive services to the adolescent parents are limited. In Baltimore City there exists the largest percentage of births to young parents. Baltimore City is fortunate to have programs at Johns Hopkins Hospital, the Laurence Paquin Junior/Senior High School and in the regular schools. In addition, several high schools have child development laboratories where it is possible for young parents to place their children. In spite of the existing programs there is a need for expanded services, and a great need for increased services to the young parent 16 years of age and under.

The passage of HR 12146 is imperative. Although resources exist in many Maryland communities and across the nation, better linkages would improve with the quality and quantity of program services to the adolescent parent population. The bill promotes innovative comprehensive and integrated approaches to the delivery of services and this is very important in the 16 and under year old teen-age parent population.

For the young woman 19 years of age and under, the knowledge and availability of contraceptives has not prevented unwanted pregnancies. This is disucssed by Melvin Zelnik and John F. Kantner in their recent study published in the May-June, 1978 issue of Family Planning Perspectives. There is an inconsistent use of a birth control method by this high risk population. HR 12146 would make it possible for existing comprehensive programs to continue to study in depth and develop creative/innovative resources with an evaluative structure to produce effective ways of preventing and reducing pregnancies in this high risk population.

As the Chairperson of the Maryland Governor's Commission on Children and Youth, I hope this Committee will give HR 12146 favorable consideration. The future of our country depends upon helping todays adolescents become productive independent contributors to family and community life.

Vivian E. Washington, Chairperson
Maryland Governor's Commission on Children
and Youth

VEW/jew

NATIONAL CONFERENCE

OF CATHOLIC CHARITIES

OFFICE OF THE EXECUTIVE DIRECTOR

1346 Connecticut Avenue, N.W., Suite 307 • Washington, D.C. 20036 • (202) 785-2757

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July 7, 1978

Honorable Harrison Williams, Chairman
Committee on Human Resources
United States Senate
Washington, D. C. 20510

Dear Senator Williams:

Because of scheduling difficulties we were not able to present oral testimony to your Committee on what we consider a very important piece of legislation -- the Adolescent Health Services, and Pregnancy Prevention Act of 1978. However, we are glad to have this opportunity to share with you our comments on this bill, based on our long history of service to unmarried mothers of whatever age. We ask that our statement be included in the hearing record.

As our enclosed statement points out: "Adolescent pregnancy, as a consequence of acting out sexuality, needs to be assessed in a social context. The origin of the problematic behavior is rooted in the families of the children, in a high proportion of cases." However, the legislation as drafted, seems to ignore, perhaps unintentionally, the importance of the role which the family of origin should rightfully have at this time of crisis. We have made several suggestions which would strengthen the role of the family and we hope the Committee will be able to accept these suggestions at its markup.

Also, we would like to call to your attention the tremendous contribution the family service agencies and maternity homes have made in easing the burden of unmarried parents over the years and we strongly recommend that these institutions be placed high on the list of facilities eligible for grants to carry out the purposes of the act.

Sincerely,

M. H. Ahmann

Mathew H. Ahmann
Associate Director for Governmental Relations

Statement of the National Conference of Catholic Charities on the Adolescent Health Services, Pregnancy Prevention Act of 1978 (S. 2910/H.R. 12146) to the Senate Committee on Human Resources and the House Subcommittee on Health (Interstate and Foreign Commerce)

The National Conference of Catholic Charities has a deep concern for the teenage mother and her child to whom services would be provided by the Adolescent Health Services, Pregnancy Prevention Act of 1978, the legislation which is before you now.

The adolescent pregnancy problem has been well documented for years, and though we are aware that the problem has become more urgent in the past decade, the history of Catholic Charities involvement with the problem goes back 250 years to a time when the Ursuline nuns came from France to New Orleans to establish a refuge for women and orphans. At that time, as today, the object of Catholic Charities was to serve the expectant mother as a whole person rather than just treat a problem pregnancy. Accordingly, she was provided with counseling, shelter, health care and training and education to make her economically independent. The same services are offered to those in need today by the Catholic Charities Movement through its 815 agencies, branch agencies and institutions. NCCC is the largest non-profit human service organization serving the American people today and in 1976 (latest figures available) provided services for 31,897 unwed mothers, 6,218 unwed fathers and maternity home care for 4,450 women.

The National Conference of Catholic Charities strongly supports the identification of "adolescent initial and repeat pregnancies" today as a major social problem in the United States. We agree that because of the serious negative consequences to the individuals, families and communities involved, the magnitude of

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the problem, and the widespread geographical distribution of adolescent pregnancies there is need for the federal government to give attention to it in a specialized program, with investment of federal financial resources to enable communities in their effort to contain or eliminate the problem or to mitigate the negative consequences on the child, the adolescent parents and their families, when a pregnancy has not been or cannot be prevented.

We agree with the findings on which the legislation is based and with the intent of the legislation as stated in the bill. We do believe, however, that some modifications in the wording in several places and the addition of a relatively small number of statements in the section on purpose, services and priorities would strengthen the ability of the legislation to accomplish its purpose.

Findings and Purposes

The fundamental problem is not the fact of unwise pregnancies leading to the birth of children who have neither an adult father or mother to assume the parental role, serious as this problem is. The fundamental problem is the lack in the contemporary American culture of objective behavioral norms to guide the adolescent, and of moral standards against which the adolescent and society can evaluate the behavior, as well as the lack of environmental controls to afford protection against destructive, impulsive behavior. The problem is exacerbated by the related problem of breakdown in both family life and in parental assumption of responsibility for children's behavior. In other words, we view early and irresponsible engagement in sexual activities on the part of children, which is how many of these adolescents ought to be classified, as damaging to them physically, emotionally and spiritually whether or not such activity results in pregnancy. We view it as harmful to the boy as much as to the girl and counterproductive to the normal maturation process in adolescence. The acting out sexuality is the problem, not merely the pregnancy which is only one of the negative consequences.

Accordingly we would like to suggest the following changes in Sec. 2 (a), Findings and Purposes:

From: (1) adolescents are at a high risk of unwanted pregnancy;

To: (1) adolescents and, increasingly, children in the early years of adolescence are engaged in sexual activity that is damaging to them physically, emotionally and morally and is counterproductive to the normal maturation process in early adolescence. As one consequence, adolescents are at a high risk of pregnancy;

From: (5) the problems of adolescent pregnancy and parenthood are multiple and complex and are best approached through a variety of integrated and essential services:

To: (5) the problems of adolescent acting out sexuality, pregnancy and parenthood are multiple and complex and are frequently associated or rooted in a problematical situation in the family. They are best approached through a variety of integrated and essential services.

In (6) insert the phrase "nor their families" so that it would read:

(6) such services, including a wide array of educational and supportive services, often are not available to the adolescents who need them, nor to their families, or are available but fragmented and thus of limited effectiveness in preventing pregnancies and future welfare dependency;

Paragraphs (2) (3) (4) and (7) of this section would remain unchanged. NCCC accepts and deplores the findings in these sections — the number of pregnant adolescents (one million in 1975); the severe adverse health, social, and economic consequences for both mother and child; the evidence of repeat pregnancies and the necessity for a federal policy to develop appropriate health, educational and social services where they are lacking.

USES OF GRANT

We note that the funds provided under this Act may be used by grantees to (1) link services to prevent initial and repeat pregnancies and to assist adolescents to become independent and productive; (2) to identify and provide access to other services; (3) to supplement services not adequate in the community; (4) to plan for administration and cooperation of services; (5) to provide technical assistance and (6) training.

Adolescent pregnancy, as a consequence of acting out sexuality, needs to be assessed in a social context. The origin of the problematic behavior is rooted in the families of the children, in a high proportion of cases. Siblings of the pregnant adolescent and of the putative father are very often and predictably apt to follow the same pattern of behavior.

As drafted, the program proposed appears to address neither of these factors although we recognize this omission was not the intent of the framers of the legislation. The bill appears to subsume the inevitability of continuing, widespread sexual activity in children and seeks to control one single consequence. It fails to address any services to the parents and the families of origin of the children involved. The only reference to the family is to authorize fixing fees in relation to the ability and willingness to pay the costs of service to the adolescent.

We would suggest, then, that Sec. 102 (a)(1)(A), which now reads:

"prevent unwanted initial and repeat pregnancies among adoelscents;"

be expanded to read:

"assist adolescents to develop a better understanding of the meaning of sex in human life and to change destructive acting out sexual behavior and prevent initial and repeat pregnancies."

We would also suggest adding to this section another service to become 102 (a)(1)(C);

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"assist families in which there is a pregnant adolescent and/or an adolescent and siblings at high risk to resolve the problems associated with, or causative of, the behavior."

We are also concerned that the major purpose of the bill appears not to be to provide services but to support projects that will help communities coordinate existing programs. In fact, in this bill federal support of services would be limited to 50% of the grant. NCCC does not concur that the major administrative problem is failure to "coordinate." The major problem is the complete lack of services in some communities, insufficient services in other communities or inaccessibility to services in neighborhoods or areas where they are needed most. We agree that coordination of services is an important objective but such coordination can be achieved by properly following the priorities listed in Sec. 103, (a)(3) without fixing a funding limit in the legislation. Sec. 102 (e) makes the provision that no more than 50% be spent on services and we would therefore recommend this section be struck.

Priorities, Amounts and Duration of Grants

Family service agencies and maternity homes are the two institutions which have historically carried the burden of service to unmarried parents in all age groups and have consequently had their resources stretched beyond their capacity to meet the demand for services. In many communities they are the most competent and knowledgeable resource and the one with credibility to serve as the key agency in establishing the network of coordinated services proposed in the legislation. They should certainly come high on the list of facilities eligible for grants to carry out the purposes of this legislation and their services should be made available not only to the adolescent but to the families of these children as well.

We would suggest that the phrase "and their families" be added to the end of Sec. 103 (a)(3). And in Sec. 103 (a)(4), which lists the types of facilities which shall have priority for grants, we suggest the following language be added:

> ...maternity homes which do or can be equipped to provide comprehensive services to pregnant adolescents and agencies serving families, youth and children with established programs in this area of service.

Requirement for Grant Approval

One of the objectives of the bill as stated in the short title is "to provide care to pregnant adolescents." Since the origin of the problem is frequently in the social environment, the priorities should lead off with family and parent-child counseling in order to strengthen the families of origin and to get at the causes of the behavior and provide potential for growth and change. The family is at a point of crisis when the pregnancy is discovered and it is at this point that it is most amenable and open to professional help.

This rationale applies also to achieving another objective of the bill, "to help adolescents become productive independent contributors to family and community life." This will also require family centered social services as well as direct health and educational services to the adolescent.

We believe these objectives would be better attained with some additional language in Sec. 104 (a)(5). This section lists the core services as (A) family planning services; (B) health and mental counseling; (C) vocational counseling; (D) educational services; (E) primary and preventive health services; (F) nutritional services, information and counseling. We suggest adding a new "(B)" to read: "Family and parental counseling." The succeeding paragraphs should then be designated (C) through (G).

Although the problem is identified in the bill as a serious and widespread one, the funding is established at a figure that is little more than a token in

view of the costs of service and the numbers of families and individuals involved. For instance, in most cases, one adolescent pregnancy may involve seven people — the baby, the teenage mother, the teenage father and the four parents of the teenagers.

Because of the number of people involved and because of the kinds of services provided, we believe the proposed program would be best administered by the Office of the Assistant Secretary for Human Development in HEW rather than in an office whose primary concern is in the health field.

In conclusion we wish to commend the Administration and the Congress for giving attention to this growing national problem and for its efforts to find a solution. The National Conference of Catholic Charities supports you in these efforts and we feel that the amendments we have suggested will strengthen the legislation so that the program can better meet its objectives.

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NATIONAL CONFERENCE OF CATHOLIC BISHOPS
BISHOPS' COMMITTEE FOR PRO-LIFE ACTIVITIES
1312 MASSACHUSETTS AVENUE, N.W. • WASHINGTON, D.C. 20005 • 202/659-6573

August 8, 1978

Honorable Harrison A. Williams, Chairman
Senate Committee on Human Resources
4230 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Williams:

Enclosed is a statement on S. 2910, The Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978, that I am submitting for the record on behalf of the United States Catholic Conference.

As we understand it, the original intent of the proposed legislation was to provide education, care and services to young people to help prepare them for parenthood at a time when they are mature and responsible. There is also a need to help improve the outcome of pregnancy for those adolescents who are pregnant, and to enable them to meet their responsibilities once the child is born. To accomplish these objectives, a wide range of services is needed, including education and motivation to develop a sense of responsibility in regard to sexual activity, counseling services, nutritional education, and programs of prenatal and postnatal care. In many cases this requires a unified approach by agencies in the community that have already demonstrated their ability to provide the necessary services. But all the information, counseling and services may have little long-range effect unless young people are motivated to exercise self-restraint and responsibility. This focuses on the role of parents, who very often need the help of the community, the churches, and at times, the professional groups.

We hope the information provided during the hearings on S. 2910 will help the Committee to appropriately revise the bill so as to meet the needs of adolescents and their families.

Respectfully,

Msgr. James T. McHugh
Director

JTM:tdm
Enclosure

STATEMENT OF THE UNITED STATES CATHOLIC CONFERENCE

ON THE ADOLESCENT HEALTH, SERVICES AND

PREGNANCY PREVENTION AND CARE ACT OF 1978.

Considerable public attention has been focused on the matter of teenage pregnancy, and the Carter Administration and members of Congress have expressed concern and determination to utilize public resources to try to deal with the problem. We share the concern about teenage pregnancy, and we agree with the basic purposes of the bill, that is, to provide assistance to pregnant adolescents and to reduce the overall number of out-of-wedlock teenage pregnancies.

Notwithstanding our agreement with the basic purposes, we find that the legislation as proposed can and should be improved.

To begin with, the reasons for the bill as expressed in Sec. 2 (a) are somewhat misleading and should be more carefully written. The statement that "adolescents are at a high risk of unwanted pregnancy" is general and over-broad, and seems to create a crisis atmosphere in regard to teenage pregnancy. While it may be true that pre-marital sexual activity among teenagers has increased during the past twenty years, it is also true that overall rates of teenage childbearing have actually declined from 97.3 (per 1,000 women aged 15-19) in 1957 to 56.3 in 1975. The actual number of births to teenagers has remained about the same because of the relatively larger proportion of teenagers in the population. (Cf. the attached letter from Science, 31 March 1978, pertaining to this matter.)

The bill also makes reference to health and social problems associated with teenage pregnancy. For the sake of accuracy it is fair to note that many of the health problems are the result of poor nutrition and dietary habits, smoking, the use of alcohol and drugs, and generally poor self-image and maturity.

As Professor Frank Furstenberg notes in his study, "The widespread conviction that early childbearing precipitates a number of social and economic problems is founded on surprisingly little evidence." (Furstenberg, Frank, Unplanned Parenthood: The Social Consequences of Teenage Childbearing, (1976) New York, The Free Press.)

Attached is a reprint of the article "Abortion and Teenage Pregnancy", from the 1977 Respect Life Handbook which provides a careful analysis of teenage pregnancy. There seems to be some agreement among the specialists that the problem of teenage pregnancy is complex and that the factors influencing out-of-wedlock pregnancy are complex, but there is little agreement as to the solutions to the various problems.

The bill repeatedly speaks in terms of preventing teenage pregnancy. Unfortunately, the legislation leans toward programs of contraception, sterilization and abortion as the means of preventing births, but gives far too little recognition to the need for education, counseling and assistance to parents in motivating their adolescents to exercise self-restraint in regard to sexual activity and behavior. The proposed legislation is admittedly vague in regard to how teenage pregnancy is to be prevented, and how agencies providing services to teenagers will respect parental rights. Once again, there is a growing awareness that simply providing contraceptive services will not effectively solve the problem. As Kingsley Davis noted in a report to the Commission on Population Growth and the American Future, "The current belief that illegitimacy will be reduced if teenage girls are given an effective contraceptive is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline, while trusting some technological device to extricate society from its difficulties. The irony is that the illegitimacy rise occurred precisely while contraception was becoming more, rather than less, widespread and respectable."

The proposed bill should be more explicit in assuring safeguards for informed consent on the part of teenagers who utilize services provided by governmental agencies and non-governmental agencies supported in whole or in part by government funds. This would extend to agencies that are part of any network or linkage as described in the bill. Informed consent has increasingly been looked upon as a way to safeguard freedom, and is especially important when dealing with matters of human sexuality. In addition, the bill should require participating agencies to establish mechanisms that will protect parents rights, notably the right to be informed regarding contraception, sterilization and abortion.

There is special need for informed consent provisions to protect teenagers and their families not only from direct coercion, but also from any subtle coercion regarding so-called "ideal family size", the dynamics of population growth, unsubstantiated predictions regarding the effects of childbearing on the future life of the adolescent.

To accomplish the purposes of the act, Title I establishes a "Grant Program" which authorizes grants to non-profit agencies. We believe that many agencies of the Catholic Church are already engaged in programs that would qualify them for grants. We urge Congress to emphasize that such agencies are not to be excluded because of the Church's moral teachings on abortion, sterilization and birth control. We also urge the Congress to caution other agencies against encouraging or promoting bias or prejudice against the Church and its agencies. We raise this point because there have been recent indications that some agencies involved in government-funded family planning programs have engaged in such anti-Catholic activities.

We also urge that agencies providing a specific service, such as a home for unwed mothers, not be forced to provide other services, such as abortion, sterilization and contraception, that are in conflict with the agency's moral principles. Valuable as the "linkage" concept may be to pull together already existing services, it should not impede the expansion of successful programs nor become an obstacle for an agency that has already demonstrated its competence in meeting the needs of pregnant women and their unborn children or new mothers and infants.

The bill as presently written seems to place heavy emphasis on the prevention of teenage pregnancy, but "prevention" is nowhere carefully defined. Abortion and sterilization should be absolutely excluded from any governmental program. Abortion involves the destruction of life of an unborn child, who is clearly an innocent party. In regard to sterilization, the potential for abuse has already been demonstrated both here and abroad. Moreover, contraceptives should not be provided to teenagers as a matter of government policy. This is a matter for the family and parents to deal with, and the government should not establish policies that preempt the prerogatives or responsibilities of the family unit. Greater emphasis should be placed on the programs and services that will assist pregnant teenagers to carry their unborn children to term, and to fulfill the responsibilities of parenthood.

At the same time, the bill should address the prevention of first or repeat pregnancies among unwed teenagers in terms of programs that assist and support families and programs that inform and motivate teenagers to avoid pre-marital sexual activity. Other Committees of the Congress have held hearings on the question of adolescent pregnancy and sex education, and the concept of education seemed to be unduly narrowed to providing information on and access to contraception. We believe that education is a much broader concept, and that efforts must be taken to assist families in the fulfillment of their educational role and provide resources that will enable parents and adolescents to work out the problems of sexual development together in a harmonious manner.

Conclusion

The United States Catholic Conference wishes to be on record in support of government assisted efforts to provide assistance and care to pregnant teenagers so that they may carry their children to term. We agree with the basic intent of the Congress to meet this need and to help diminish the incidence of out-of-wedlock teenage pregnancies. The teenage pregnancy bill may be a useful means of accomplishing these goals, and we urge a further revision of the proposed bill to protect the rights of individuals and families and to direct the energies of government and private agencies in appropriately assisting families, parents and pregnant adolescents.

Teenage Pregnancies

In discussing the proposed increase in the budget of the National Institute of Child Health and Human Development, Barbara J. Culliton (News and Comment, 3 Feb., p. 508) uses the term "epidemic" to refer to teenage pregnancies. This is a scientific term and should be used with caution. The rate of teenage pregnancy may well be increasing, but we do not have a reliable direct measure of conception rates, and not all increases over time deserve the term "epidemic." It would seem safer to focus on age-specific birthrates. They have been falling since 1969 for 18- to 19-year-olds; they were approximately steady from 1970 to 1973 and have been falling since then for the 15- to 17-year-olds; and they have been approximately steady since 1970 for the 10- to 14-year-old group (*1*). The total number of births to teenagers has been falling since 1970. In the face of these data, the term "epidemic" seems unwarranted. What has been increasing rapidly are society's awareness of and concern about teenage pregnancies.

Culliton also notes that more than half of the estimated 1 million teenagers who became pregnant last year chose to keep their babies. This information is misleading. The Alan Guttmacher Institute (which made the estimate) suggests that more than 400,000 of those pregnancies ended in miscarriages and abortions and less than 600,000 in births (*2*, p. 10). The figure for 1975 (the latest year for which published data are available) was 594,880 live births to females under 20. But more than half, 354,968, were to 18- and 19-year-olds. Moreover almost 250,000 of these, or 70 percent, were married (*1*; *2*, p. 11). Thus approximately 42 percent of the live births to women under 20 were to married 18- and 19-year-olds.

Many may believe, and we may agree, that childbearing should be delayed until the mother is in her 20's, but there is nothing immoral, illegal, or contrary to this society's values about 18- and 19-year-old married women keeping their babies. Teenage pregnancy is a national problem, but its dimensions should be examined more carefully.

LORRAINE V. KLERMAN
Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University, Waltham, Massachusetts 02154
JAMES F. JEKEL
Yale School of Medicine, New Haven, Connecticut 06510

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Abortion and Teenage Pregnancy

In 1973 the U.S. Supreme Court issued an unprecedented ruling. Abortion, it said, is virtually a private matter for the woman to decide. "This right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy" (*Roe v. Wade*, slip opinion, pp. 37-38). Beginning in the fourth month of pregnancy, the Court held, the state could impose some health restrictions on the performance of abortion, if it chose to do so, and in the sixth or perhaps seventh month it could—if it so chose—extend some protection to the "potential human life" in the mother's womb (full rights of human personhood are not to be recognized by the law until at least birth). But, whether in the third, sixth, or ninth month of pregnancy, the private right of the woman to obtain an abortion is always paramount.

The Court's tragic decision is based on two fundamental errors.

First, the life of the unborn child is assigned a moral value of zero.

Second, abortion is essentially considered in a vacuum, apart from all other human relationships. The woman, in consultation with her physician, has the final power to decide whether and why the abortion should be performed. No one else has any say in the matter.

Yet—despite what the Court said—it is a fact that the generation of new human life is an event of immense social importance. Court decisions do not create this reality, nor can they destroy it. Many aspects of this process of generation are personal, but none can properly be called altogether private—that is, pertaining to the individual alone. When the Court called abortion a private matter for the woman to decide, it adopted a legal fiction—a fiction which helps society silently condone the performance of what it knows to be a morally shameful act.

At least since 1969, when national records on the subject were first kept, about one-third of all legal abortions each year have been performed on teenagers—upwards of 300,000 in 1974. Teenagers make up a significant single group of abortion recipients. They are also the most humanly vulnerable group. In what follows we shall discuss in some detail the situation of the pregnant, unwed teenager. We shall conclude with several reflections on why changes are needed in public policy.

TEENAGE ABORTION

The incidence of legal abortion has been increasing dramatically since it was first introduced in an appreciable way in several states in 1967. It is estimated that in 1975 the number of abortions in the United States exceeded one million. Apparently, the annual figure has not yet peaked (a phenomenon which usually occurs several years after a permissive abortion policy has been introduced). Teenagers, along with other age groups, have increasingly turned to abortion, and this trend will probably continue for several years.

The available data do not make it clear how many of the teenagers who obtain abortions are married and how many are not. However, it seems safe to assume that the vast majority are unmarried. The estimated national figure for unmarried women obtaining abortions in all age groups was 70.9 percent in 1974. Most likely, the figure for the teen years was even higher.

In light of this, one can hardly ignore the question of the relationship between the pregnant, unmarried daughter and her parents. This question becomes even more important when we realize that an estimated 15,000 girls under the age of 15 obtained abortions in 1974. (According to the Center for Disease Control this age group had more abortions than live births.)

CHILDBEARING AMONG TEENAGERS

Despite the contrary impression, overall rates of teenage childbearing have actually fallen in recent years—from a high in 1957 of 97.3 births per 1,000 women (ages 15 to 19) to a low in 1975 of 56.3. This substantial decline, however, has not been as extreme as that experienced by older women. For the 20-to-24-year-old age group, for example, the rate dropped from 258.1 in 1960 to 114.7 in 1975. As a result, births to teenagers now figure more prominently among all births—nearly one-fifth of all births in 1975.

While teenage birth *rates* have gone down in recent years, the number of women aged 10 to 19 years has grown—from around 15 million in 1960 to over 20 million in 1975. As a result, the annual *total number of births* to teenagers has not declined (as might have been expected from the falling teenage birth rate) but has stayed about the same (609,000 in 1960 and 594,900 in 1975).

In 1975 nearly 40 percent of all teenage childbearing was out of wedlock (233,500 births out of 594,900). In addition, it is estimated that a significant percentage of teenage marital births are conceived premaritally.

OUT-OF-WEDLOCK BIRTHS—IN GENERAL

Social scientists measure out-of-wedlock births in various ways—by total numbers, by illegitimacy ratios (the num-

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ber of out-of-wedlock births compared to the number of live births), and by illegitimacy rates (the number of out-of-wedlock births per 1,000 unmarried women of childbearing age).

For purposes of measuring general historical trends, special attention will be given here to illegitimacy rates.

From 1920 to 1940 the illegitimacy rate remained relatively stable:

Year	Total No.	Rate
1920	86,400	8.7
1930	80,800	7.8
1940	103,000	8.0

However, from 1940 to 1970 the illegitimacy rate rose steadily. By 1970 the rate had increased more than threefold:

Year	Total No.	Rate
1940	103,000	8.0
1945	128,200	10.5
1950	148,400	14.5
1955	189,700	19.5
1960	230,400	21.7
1965	297,100	23.4
1970	398,700	26.4

Since 1970 the rate has remained high, declining slightly for the most part, but with a small upturn in 1975:

Year	Total No.	Rate
1970	398,700	26.4
1971	401,400	25.6
1972	403,200	24.9
1973	407,300	24.5
1974	416,100	24.1
1975	447,900	24.8
1976	NA	NA

OUT-OF-WEDLOCK BIRTHS—TEENAGERS

From 1940 to 1965 every age group of childbearing women showed an increase in the rate of illegitimacy. Those aged 15 to 19 showed the lowest rate of increase. However, from 1965 to 1975 every age group experienced a decrease in the rate—except the 15-to-19-year-old group, among whom the rate continued to increase.

The birth rate—both legitimate and illegitimate—has been declining for women 20 years and older. But, as noted above, the overall birth rate for teenagers has not been declining as fast as that for those 20 years and older. Here, the illegitimate birth rate for teenagers continues to increase. As a result, out-of-wedlock births have become more concentrated in the teen years—52 percent of the total in 1975 (40 percent in 1955, 44 percent in 1965).

Illegitimacy Rates by Age Groups 1940, 1965, 1970, 1975

	15-19	20-24	25-29	30-34	35-39	40-44
1940	8.7	10.6	8.1	5.8	3.4	1.2
1965	17.5	39.3	48.4	37.2	17.4	4.5
1970	22.4	36.4	37.0	27.1	13.6	3.5
1975	24.2	31.6	28.0	18.1	9.1	2.6
% Change 1965-75	+38%	−20%	−42%	−51%	−48%	−42%

WHY?

Authorities disagree about what factors affect out-of-wedlock births and what should be done in response to the problem.

Improvements in health care can result in increased fertility—and thus more births, including out-of-wedlock births. The age at menarche (when menstruation first occurs) has been decreasing in the Western world for many years at the rate of four months per decade (the average age is now 12—though wide variations occur). Presumably this has been occurring as a result of improved health conditions. The young adolescent may not be fully fertile, however, for another two and one-half or three years following the onset of menarche. In light of these two facts, one authority estimates that between 1940 and 1960 fertility was increasing among women 15, 16, and perhaps 17 (Cutright). Improved health care presumably has also led to a reduction in spontaneous abortion and to reductions in involuntary sterility (primarily for women beyond their teen years).

However, these health factors certainly do not fully explain the rise in illegitimacy rates since 1940. And in no way do they explain the declines since 1965 among women aged 20 or older.

One study concluded that, beyond improved health conditions, the main factor in the rise in the illegitimacy rates between 1940 and 1960 was an increase in sexual activity (Cutright).

This is the conclusion of one study, and it is not the last word. More important, changes in sexual behavior are themselves related to other social changes and conditions, especially changes in family structure and social policy toward the family.

One authority considers the rise in premarital pregnancies and the rise in the rate of teenage marriages following World War II to be closely tied to economic and social changes of that time (Weeks).

Let us look at teenage childbearing behavior in particular in the 1960s and 1970s.

The incidence of teenage out-of-wedlock childbearing will be directly affected by the incidence of teenage marriage. Some argue that at the beginning and end of the period 1960 to 1974 the percentage of teenage *births* conceived out-of-wedlock remained about the same, but, because of a downturn in teenage marriages, the proportion of these births that were actually *born out-of-wedlock* increased substantially (Campbell).

This analysis does not claim that the level of teenage non-marital sexual activity or the incidence of teenage out-of-wedlock conceptions had not increased. As stated above, since the late 1960s teenagers have increasingly turned to abortion as a solution to the out-of-wedlock pregnancy. Other studies indicate that nonmarital teenage sexual activity has been increasing in recent years (Zelnik and Kan[illegible]). With respect to the increase in teenage sexual activity, Weeks states that "the breakdown in social control during the 60s and early 70s is quite striking" (Weeks, p. 58).

Some studies correlate the availability of legal abortion with recent declines in the rate of illegitimacy (Sklar and Berkov). Increased use of contraception may also account for some of the decrease.

Not surprisingly, some advocate contraception and abortion as the means to combat teenage illegitimacy.

However, the use of contraception by the unmarried teenager is notoriously ineffective. Unmarried, emotionally immature teenagers are not the same as married, emotionally mature adults. As it is, the failure rate in contraceptive use among married adults is fairly high (Cutright, pp. 417-418). In contrast to the married, the sexual behavior of the unmarried teenager is irregular, infrequent, and generally unplanned. Further, the behavior is often highly romanticized and the values of "spontaneity" and "naturalness" may be highly prized. Recent studies also show that sexually active teenagers possess a poor knowledge of the biology of reproduction (Zelnik and Kantner).

For reasons such as these, those who advocate contraception as a solution for the problem of out-of-wedlock teenage pregnancies consider abortion as an essential "backstop" method. An abortion will surely prevent a birth.

From 1965 to 1975 abortion and contraception were increasingly available in American society—but during this period the teenage illegitimacy rate continued to increase (though at a slower pace). One should anticipate that in the future abortion will be of even greater importance as an essential "backstop" for the "pragmatic" problem solvers.

Predictably, those promoting teenage contraception and abortion are looking for ways to make contraception and abortion more "accessible" to the unmarried teenager. Emphasis has shifted from community clinics to the schools.

In recent years, legal and social barriers inhibiting teenage access to contraception and abortion have become less and less. However, the natural barriers to effective use may very well remain.

Even if efforts to make contraception and abortion more "accessible" should succeed in "solving" the problem of out-of-wedlock teenage births, would we be a better society for it? What problems would have been left unattended? What new problems would have been created?

THE SOLUTION: A MORE REFLECTIVE LOOK

One sociologist scores the advocacy of contraception for teenagers as typical of the American character—a misplaced trust in technology to solve human problems:

> The current belief that illegitimacy will be reduced if teenage girls are given an effective contraceptive is an extension of the same reasoning that created the problem in the first place. It reflects an unwillingness to face problems of social control and social discipline, while trusting some technological device to extricate society from its difficulties. The irony is that the illegitimacy rise occurred precisely while contraception was becoming more, rather than less, widespread and respectable (Davis, p. 253).

The same could be said about abortion as a problem solving tool for teenage out-of-wedlock births.

It is often assumed that little or nothing can be done to affect the sexual behavior of teenagers. At the same time, studies are produced which show that teenage sexual behavior has been affected—over the last several years it has increased. Today, US teenage childbearing rates are among the highest in the world—higher even than those in many less developed nations. Are we to assume that teenagers in third world countries are more effective contraceptors and have greater access to abortion? Or that only health conditions explain the differences?

The sexual behavior of teenagers not only can change over time but can vary among individuals and groups. For example, teenage girls who are more highly motivated to achieve future goals are more likely to delay the initiation of sexual activity—and thus the possibility of an out-of-wedlock pregnancy (Furstenberg, 39-42).

American culture currently romanticizes sexual activity. It was not always so. However, teenagers—growing up, experiencing life for the first time, looking to authority figures outside the family—are most susceptible to the new cultural "norms."

The problem is only compounded by the fact that other societal patterns—even laws—separate parent and child. In some instances society seems to expect each individual teenager to discover the meaning of human life all alone. In such a system of moral development many serious and permanent mistakes will be made. The gifted few may succeed. Would we leave teenagers to their own devices with respect to intellectual development? Society—both from within the home and from outside the home—has always exercised guidance and discipline in the moral and social development of its teenage members. This guidance and discipline is no less important today than in the past.

Breakdown in social controls over sexual activity are not always entirely obvious. Studies show that nonmarital teenage sexual activity is often initiated at the insistence of the male. One way of controlling the nonmarital sexual activity of the male in the past was through paternity laws—but these now are often meaningless in practice. (In this sense, is abortion on request the logical out-

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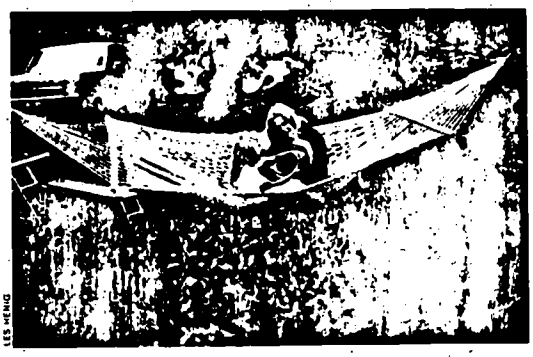
come of a lessening of the male's responsibility for his sexual actions?) At the same time the social structures that used to ensure an orderly process in the selection of a marriage partner are no longer or not always there. As a result, the woman's search for a marriage partner—in the marriage oriented society that we still are—is more apt to begin earlier, and end either in an out-of-wedlock pregnancy or a teenage marriage.

Social factors—at first glance apparently unrelated—may affect the incidence of teenage out-of-wedlock births. Studies show that the majority of nonwhite as well as white teenage girls hold nonmarital sexual activity to be morally wrong. However, whites more than nonwhites are more likely to legitimate an out-of-wedlock pregnancy by marriage. Some postulate that marriage might only aggravate the economically disadvantaged positions of the nonwhite. It might be several years before the teenage father would have a job that could support a family adequately. At the same time, the teenage mother would be separating herself from the immediate support of her existing family unit (Furstenberg, pp. 68, 71-75)



LES HENIG

OUT-OF-WEDLOCK BIRTHS— THE EXTENT OF THE PROBLEM

Those who advocate contraception and abortion as the solution to teenage out-of-wedlock births may not necessarily perceive the basic problem in the same way.

Some emphasize the reduction of all teenage childbearing—marital and nonmarital—and, in this sense, the concern should perhaps more properly be classified as population control.

Others stress the special social and medical problems associated with teenage out-of-wedlock childbearing.

A recent study concluded: "The widespread conviction that early childbearing precipitates a number of social and economic problems is founded on surprisingly little evidence" (Furstenberg, p. 12). It is not that such problems do not exist (the study confirmed the general impression that they do), but that their precise nature is not well understood and, as a result, inadequate solutions are proposed.

This same study found that over a five-year-period some teenage unwed mothers succeeded where others, in the same general circumstances, did not. "One of the most impressive findings was the diversity of responses to a common event. The outcome at the five-year follow-up was enormously varied. In fact, by the time of the last interview, the sample hardly could have been more diverse in every important area we explored" (Furstenberg, pp. 218-219).

The most important question is whether any medical or social problems are so great as to justify the taking of unborn human life. The Church's teaching on respect for human life shows the principle that underlies this kind of problem solving to be incompatible with human dignity. Innocent human life can never be taken just because to do so is pragmatic—that is, it is possible, it is easier than its alternative, it "works," so it should be done. The humane way may very well be the more challenging way.

We must ask not only what are the human costs of bearing a child out-of-wedlock, but what are the human costs of aborting this yet unborn child. Is the loss of human life nothing? Does the woman who consents to the destruction of the new life within her remain indifferent to the act—or is a sense of freedom that a "problem" has been gotten rid of a morally praiseworthy quality? What is the effect on society itself when it adopts highly utilitarian social policies which violate fundamental human rights?

In the case of adolescent girls, there is already some realization that they become resentful of parents who force "the abortion solution" on them. Moreover, abortion counselors tell young people to expect some alteration in the boy/girl relationship after the abortion. The young woman especially has a changed attitude toward the boy, and apparently many of these relationships disintegrate rapidly.

As a medical procedure abortion presents threats to the life and health of any woman. But the adolescent girl is at risk in several respects. The teenager is more apt to delay seeking an abortion. But late-term abortions are medically the most dangerous kind. Yet the full-scale educational effort to convince teenagers that sex is a simple, uncomplicated fact of life and that, if they become pregnant, abortion is available on request, is generating pressure which leads teenagers to abort, glossing over the important fact of inherent danger.

It is commonly assumed that a young unmarried girl can abort an existing pregnancy and have children later when she wants them. But things may not be that simple. For example, studies—in various parts of the world—are showing that young women whose first pregnancies are aborted are much more likely than average to have subsequent pregnancies which result in premature births. Prematurity, in turn, has long been known to be associated with an increased incidence in cerebral palsy, mental retardation, and lesser forms of damage to the central nervous system.

such as learning disabilities (Hellegers). As abortion becomes the solution to premarital pregnancies, married couples and society may later have to pay the human and financial costs of a growing number of mentally and physically damaged children.

There is every reason to expect that young women who are rushed into abortion by social and cultural pressure will distrust and resent a society that misled them about the nature and long-range affect of the action they were encouraged to undertake.

Teenage pregnancy is not simply a result of ignorance or failed contraception. In many cases, the teenager's sexual irresponsibility is a symptom of personal insecurity—of a need for love, affection, and self-affirmation. Pregnancy is not necessarily unintended or unforeseen. And, while pregnancy may complicate existing personality difficulties, in such cases, so also the destruction of the unborn child may simply reinforce the teenager's low estimate of herself or diminish her perceived ability to cope with and overcome problems. Destroying the fetus in such cases may well be a weapon for destroying the mother, too.

SOCIAL AND PUBLIC POLICY

Today, sexuality is often regarded as a plaything. In such an almosphere it is not surprising that sexual relationships between men and women tend to become exploitative while the broader social ramifications of human sexuality are lost sight of or are even positively rejected. The newly conceived human life is often described as an intruder. When human sexuality is not accorded its proper dignity, it is consistent—though sad—that the unborn child, the fruit of the human sexual relationship, is regarded as nonhuman.

Examination of the facts about teenage childbearing, especially teenage out-of-wedlock births, makes it clear that "adult" standards of moral conduct are being extended to the not-yet-mature adolescent. But in this area, as in others, contemporary society suffers from moral impoverishment. Thus, the not-yet-mature adolescent will not find life guidance in the not-yet-mature standards of society at large.

The notions of social control and social discipline refer to more than parents' responsibility for their children. General social policy toward the family will condition the expression of family relationships.

Americans have traditionally considered freedom as both a social and personal value. Increasingly, however, freedom is being seen simply in terms of the individual. American public policy seems to have adopted this more narrow viewpoint.

But absolute or virtually absolute personal freedom is quickly emptied of meaning. The other goods of the human person, as well as the manifest goods that flow from human relationships, will time and again be compromised in the name of a nebulous, all-pervasive individual freedom.

The individual is never perfectly autonomous. Whether or not it is acknowledged, there always exists a tension between personal freedom and the good of society. Nowhere is this more evident than in the family, where the individual establishes self-identity and exercises his or her freedom while respecting the rights of other family members and the good of the family unit.

The threats to the family posed by an excessive concentration on individual freedom were graphically expressed by the U.S. Supreme Court in its 1973 abortion decisions.

These decisions represent the culmination of Court decisions over a period of several years which were unfavorable to the family (Noonan). Furthermore, on July 1, 1976, the Court issued another round of abortion decisions—with specific reference to the family. It ruled that the woman's right to abort the child within her can be exercised without her husband's consent, or, if she is a minor, without her parent's consent (*Planned Parenthood of Central Missouri* v. *Danforth*).

Several public policy recommendations require attention.

- The fundamental errors of the 1973 abortion decisions must be corrected. The most viable way to do this is through an amendment to the U.S. Constitution guaranteeing the basic right to life of the living but unborn child.
- The United States needs to develop a family policy that is positive toward and supportive of family life. Such a policy must extend beyond a narrow concern for the techniques of family planning and must be based on a broader vision which respects and encourages the basic goods of human life.
- Government policy and programs should be directed at removing those conditions which tempt or in some sense force a woman to turn to abortion to solve problems. Societal attitudes toward out-of-wedlock pregnancies have changed. The recriminations that society traditionally leveled at both unwed mother and child have been more and more put aside—and rightly so. No girl pregnant out-of-wedlock should be abandoned to her own resources—and perhaps to an abortion. And no child should have to suffer any legal or social restrictions because he or she has been designated illegitimate.

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National Conference of Catholic Bishops
Washington, D.C.

NATIONAL COUNCIL OF JEWISH WOMEN
15 EAST 26th STREET, NEW YORK, N.Y. 10010 · (212) 532-1740

ESTHER R. LANDA, NATIONAL PRESIDENT

MARJORIE MERLIN COHEN, EXECUTIVE DIRECTOR

July 27, 1978

The Honorable Harrison A. Williams, Jr., Chairman
Committee on Human Resources
U.S. Senate
Washington, D.C.

Dear Senator Williams:

Attached is the statement of the National Council of Jewish Women for the record of the hearings of the Senate Committee on Human Resources on S. 2910, the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978.

We are most appreciative of your request that we testify on the legislation proposed to address the critical problem of teenage pregnancy. In examining the bill, our women found that it involves issues that have been major concerns of our organization in recent years:

1. Cooperative efforts of public and voluntary sectors, including coordination of services;
2. Justice for Children, including the right to educational and job training opportunities, to health care, and to protection from abuse/neglect;
3. Child Development, including adequate child day care meeting standards that protect children, comprehensive health screening and medical care, family life and sex education, support services for family stability, such as comprehensive emergency services for children at risk;
4. Women's Issues, including the right to freedom of choice for abortion, regardless of financial means;
5. Adequate funding of programs to meet human needs, including raising the ceiling set in 1972 for funding services under Title XX of the Social Security Act.
6. Constitutional Rights, including confidentiality of medical records.

We hope that the information will be useful in your considerations.

Sincerely yours,

Esther R. Landa

Esther R. Landa
National President

WASHINGTON OFFICE, 1346 CONNECTICUT AVENUE, N.W., SUITE 924, WASHINGTON, D.C. 20036 · (202) 296-2588

NATIONAL COUNCIL OF JEWISH WOMEN
15 EAST 26th STREET, NEW YORK, N.Y. 10010 - (212) 532-1740

ESTHER R. LANDA, NATIONAL PRESIDENT — MARJORIE MERLIN COHEN, EXECUTIVE DIRECTOR

STATEMENT FOR THE RECORD OF THE HEARINGS ON
S. 2910, THE ADOLESCENT HEALTH, SERVICES AND
PREGNANCY PREVENTION AND CARE ACT OF 1978,
SENATE COMMITTEE ON HUMAN RESOURCES

The National Council of Jewish Women, an 85 year old organization of 100,000 members, is a volunteer organization dedicated to advancing human welfare and the democratic way of life through a coordinated program of education, service and social action in the Jewish and general communities, locally, nationally and internationally. It has a long history of concern about families, teenagers and children, and in many local communities is now focussing on the problems of pregnant adolescents and teen mothers.

At its biennial convention in New York in March 1977, the National Council of Jewish Women adopted the following statement as introduction to its resolutions on Health and Welfare:

> The National Council of Jewish Women believes that a healthy community, sound family life and individual welfare are interdependent. It believes, therefore, that our democratic society must give priority to programs which meet human needs and that the public and private sectors must cooperate to achieve this end.

We are most appreciative of the opportunity to submit comments on legislation proposed to address a critical community problem, nationally, one that has been with us for many years and has been increasing. We recognize the importance of the purposes of the Adolescent Health, Services and Pregnancy Prevention Act of 1978. We endorse its requirement that there be no income eligibility for

services, but there are several aspects of the proposed legislation that are of concern to us:

a) The lack of coordination of programs within the Department of Health, Education and Welfare, relating to teen-pregnancy services, may be a deterent to effective coordination in the local community.

b) Communities already well-organized, especially large cities, will be in a much better position to submit early proposals, and there will be no funds remaining for those without service currently and most in need of them.

c) The limitation of the Federal grant, not to exceed 70% of the costs of the project for the first two years, may make it impossible for participation of voluntary (private non-profit) agencies with a proven record of working with teen-age girls, such as YWCA and Girls Clubs.

d) The funds provided may well be insufficient to purchase needed services not available currently because of lack of funds (or because the teen mother is not eligible), such as day care so the mother can return to school or to a vocational skills training program.

e) The pregnant teen-ager must have counseling on the full range of alternatives available, including abortion.

f) Little attention may be given to developing more effective programs to prevent pregnancy of the very young teen-agers, or for adequate funding of programs already developed which have caused a reduction in the number of pregnancies of older teen-agers, because of the pressing needs for services by the pregnant teen-ager and the teen-mother.

Additional concerns are included with community experiences cited.

Some of the community experiences which led to these concerns may clarify them: NCJW members probably faced the in-depth problems of teen pregnancy and teen mothers as a national problem for the first time when they began to screen young women for Job Corps early in 1965 as part of the national coalition, Women In Community Service, with Church Women United, National Council of Catholic Women, National Council of Negro Women and later joined by the American GI Forum Auxilliary. At that time we found 14, 15, 16 year old mothers no longer in school, desperately wanting education and training for employment to support their child. Often just one voice raised to a school superintendent had been sufficient to exclude pregnant girls from school state-wide, to avoid "contaminating" other girls. In Virginia the National Council of Jewish Women took the initiative, with the support of the WICS coalition and the AFL-CIO Appalachian Council, and worked with state legislators to bring about a change of policy by the State Board of Education, so that programs were begun to keep pregnant teen-agers in an educational program while awaiting the birth of the child, with return to classes afterwards.

In the WICS orientation programs to prepare the young women for the new experiences ahead of them in Job Corps, we found that in most communities, school programs on family life and on sex education were inadequate or non-existent because of the pressure of a small vocal group who appear to consider knowledge dangerous, even perverting.

In Denver WICS found that teen mothers who went to Job Corps for training were able to find jobs on their return home, but were unable to work because there was no child care available after the

Job Corps child care allowance ended. So WICS established a day care center. The Atlanta Job Corps Center experimented with a day care center for children of residential enrollees, and at the same time used the program to teach child care and parenting skills to all enrollees. The problem of child care for infants and toddlers of enrollees is still with Job Corps, as evidenced by the Rainbow Nursery, recently opened in Portland, Oregon, by a coalition of WICS, Job Corps and the First Baptist Church, to care for five infants and toddlers of non-residential enrollees of the Portland Job Corps Center. It also provides parenting skills classes for Job Corps students, as well as informal guidance for the parents. Enrollment was limited to five by the fire code, not by child care needs.

In the intervening years we found that the problems of preventing pregnancy, of the pregnancy itself, and of parenthood, that we first saw in teenage girls applying to Job Corps from both urban and rural low income families, are not confined to welfare or low-income communities. As the societal patterns changed and most teen mothers kept their babies instead of releasing them for adoption, the problems have been found as well in higher income families. Often teen mothers from working families are not eligible for services available at public expense to those from the lowest income families. When they remain in their own homes, they may not be able to attend school because there is no child care available, and the family cannot afford the cost of day care. And the schools will say that noone is out of school because of lack of child care! If the community has a well-baby clinic, or in New York State a Child Health Assessment Program (CHAP) Clinic, then the baby has the necessary periodic

pediatric examinations and immunizations. But if the infant becomes ill or is in need of expensive treatment for a birth defect (more common with teen pregnancies), the mother's family frequently cannot afford the medical expenses. Some girls become emancipated minors and go on AFDC rolls in their own apartment, so that the child can have needed medical services paid by Medicaid, at the very time the young mother is most in need of family support. With younger teenagers, the mother and child may both be placed in the same foster home, so that she can attend school.

As NCJW members have become involved in community programs to prevent abuse and neglect of children, they have become aware that many teen mothers lack parenting skills, frequently leading to neglect and even abuse, another urgent reason for the coordination of services proposed by S. 2910.

But there is nothing in the proposed legislation which would require that HEW determine if a services coordinating agency or system already exists in the community before funding a new coordinating agency through S.2910. There have been strong efforts in every HEW region to replicate some form of Nashville's Comprehensive Emergency Service (CES) for Children at Risk, with either a public agency or a voluntary (private non-profit) agency providing the linkage mechanism for all services in the community. Other communities have developed their own patterns for coordinating services to vulnerable families. There have also been statewide efforts by state governments, some only just underway, such as New York State's Council on Children and Families.

Nor is there any indication in the legislation as to who will

make the choice and under what criteria if more than one agency from a community submits a proposal to establish a coordinating mechanism funded by S. 2910.

That the voluntary sector can provide creative programs to meet the needs of teenagers has been clearly demonstrated under funding from the Juvenile Justice and Delinquency Prevention Act of 1974 as amended in 1977. There are two provisions in that legislation which have made it possible for innovative programs to meet local needs, to be developed by voluntary agencies: 1) the elimination of any cash matching funds as a requirement for participation of private non-profit agencies, and 2) the setting aside of Special Emphasis Funds for voluntary agency funding of projects to at least 30% of the appropriation, to continue to attract the voluntary sector to work with adolescents at risk. The NCJW has been an active participant in pilot projects developed by the collaboration of agencies belonging to the National Assembly, with an NCJW member chairing the project in several places, including Connecticut and Tucson.

In addition, the legislation should include a specific requirement that public agencies applying for grants must coordinate efforts with the private sector. Only through the cooperation of public and private sectors can an effective community program be developed. The Juvenile Justice and Delinquency Prevention Act specifies this coordination and invites the participation of the voluntary sector. Although the funding is through the Department of Justice's LEAA, many of the public and private agencies involved would of necessity be the same agencies working to prevent teen pregnancy, to assist pregnant teenagers, and to provide support services needed by teen

mothers.

Testimony has been presented by the American Academy of Pediatrics, documenting the need for counseling services for pregnant teenagers, including alternatives if the pregnancy is unwanted or if there is abnormality or genetic defect of the fetus. These alternatives must include termination of pregnancy, available to low income adolescents as well as to those who can afford the medical costs. The NCJW also supports the Academy's suggestion that confidentiality of medical records be addressed in the legislation, including release of records by the patient to third parties, separate maintenance of confidences of parents and minors, patient access to medical records, and periodic review and expungement of medical records.

The apparent dependency for purchase of services under the proposed legislation on other Federal programs, especially Title XX of the Social Security Act, is totally unrealistic for two reasons, one more obvious than the other. All across the country such purchases of services with Title XX funds are being drastically reduced because the ceilings have long since been reached and inflation necessitates reduction in services. Consequently, the first cut-backs occur for "income eligible" families (those not receiving cash grants under Title IV-A, SSA), the very teen-agers not eligible for services now. In many communities the only teenagers eligible for publicly funded services, other than family planning, are those in the AFDC families. Further cutbacks have caused the elimination of child day care for AFDC families unless the mother is actually employed, eliminating funding of child day care for older teen mothers no longer mandated to attend school by state law, who want to attend jobs skills training

programs and complete their high school through an equivalency program, or take a two year vocational program at the community college. But while services are being reduced, there is no reduction in personnel of the public agencies. The Congress must give careful consideration to the future problems being created because the fiscal restraints have caused reductions or elimination of services to the most vulnerable segment of our population, and our most important resource -- our children.

In many communities efforts have been made to develop needed services through the use of CETA funds for personnel. The changing emphases -- that CETA placements (even public service employment) must have a strong possibility for permanent funding after the first year -- that only entry level positions at minimum wage be included -- that it must be assumed that unemployed skilled workers do not need CETA placement -- all have prevented establishment of needed services to teen mothers when efforts have been made to provide them outside of Title XX funding. An NCJW member has been involved in a two year effort to develop an infants and toddlers day care program in Beacon, New York, for teen mothers identified by the YWCA Teen Mothers Program, so that these mothers could return to school. In May 1978 there were 19 mothers identified in one neighborhood, 6 of them under 16 years of age, who could not return to school because there was no one to care for their child and no agency would pay the cost of child care. A facility was located and a sponsoring agency. The school system was willing to cooperate in having the mothers half time in school and half time in the center working under a registered nurse to assist with the care of the infants and learn-

ing parenting skills. Hopefully, service organizations would have outfitted the center. But the two positions for staff had to be eliminated from the City of Beacon's CETA program as not meeting new guidelines, and the center will not open in September. The "Concerned Agencies Group" continues its efforts to help these young women to return to school and a useful contributing adult life. The YWCA Teen Mothers Program provides a group meeting regularly, and counseling; the Dutchess County Health Department's CHAP Clinic provides pediatric well-baby services and classes in parenting skills; the Dutchess County Department of Mental Hygeine Clinic provides in-depth counseling services when needed. But teen agers need an opportunity for their own growth and development. The Beacon Opportunity Center, a branch of the Hudson Valley OIC, and Marist College's 70,001 program for training and employment of teenage drop-outs both offer educational opportunities in addition to the school system, if child care is available. Four pregnant Beacon teenagers enrolled in 70,001 in early 1978 had to drop out of the program on birth of their child because no day care was available for their babies. It is obvious that coordination of services without adequate funds to purchase needed services does not meet community needs.

In conclusion, the National Council of Jewish Women supports the intent of the Adolescent Health, Services and Pregnancy Prevention and Care Act but urges that improvements be made to ensure its efectiveness in addressing a serious national problem by the combined efforts of both the public and private sectors. Appropriate language should be added to include the intent of the following underlined

materials

Section 103.(a) In approving applications for grants under this Act, the Secretary will give priority to applicants who --

(8) will utilize an existing community services coordinating agency where one exists, rather than set up a competing mechanism.

(b) Add: Special consideration will be given to applications from communities meeting the priorities set in (a) (1), (2), (3), where there is no coordinating agency.

(c)(2) Add additional paragraph:

Public agencies applying for grants under this Act must coordinate efforts with the private sector, particularly those voluntary organizations to which adolescents come seeking other services such as counseling, social services, recreation, skills training, etc.

(3) Add additional paragraph:

The requirement for matching funds will be waived for private non-profit agencies to encourage their participation. Special Emphasis Funds shall be set aside for funding projects by voluntary agencies, to at least 30% of the appropriation.

Section 104. (a)(5)(B) health and mental counseling, including the full range of alternatives for pregnant adolescents.

(D) .... to help prevent adolescent pregnancy (mandated).....

Section 104 (a)(5)(G) Special training to providers of adolescent services so they can successfully address the needs of adolescents.

(6) Add to the list of services: foster care and adoption services;

Add:(14) Assurances that confidentiality of all medical records shall be maintained, that the patient shall have access to medical records, that such records can be released to third parties only with the consent of the patient, and that there will be periodic review and expungement of medical records.

Section 201. (a)(4) give funding priority, where appropriate, to grantees using single or coordinated grant applications for multiple programs, including private non-profit agencies; and

(b) ..... State shall coordinate its activities with programs of local grantees, if any, including private non-profit agencies, that are funded ....

In addition, the legislation should clearly spell out the responsibility of the Department of Health, Education and Welfare to provide a compendium of all sources of Federal funding to grantees for services.

1346 Connecticut Avenue N.W. Washington, D.C. 20036 (202) 785-0100

TENTH ANNIVERSARY • 1968-1978

July 12, 1978

The Honorable Harrison Williams
Chairman
Committee on Human Resources
U.S. Senate
Washington, D.C. 20515

Dear Senator Williams:

I am writing on behalf of Zero Population Growth Inc., to express our views on S. 2910, the Administration's proposed "Adolescent Health, Services, and Pregnancy Prevention and Care Act".

ZPG commends the work your committee has done to give this legislation timely hearings. Would you please enter the attached statement in the record of the committee's June 14 and July 12 hearings on S. 2910.

Thank you for your consideration of the need for federal programs to respond to the serious problems of adolescent pregnancy.

Sincerely,

Peters D. Willson

Peters D. Willson
Political Representative

PDW:hal
Enclosure

ZPG'S COMMENTS ON S. 2910,
THE "ADOLESCENT HEALTH, SERVICES AND PREGNANCY PREVENTION AND CARE ACT"

ZPG is a private, non-profit organization of citizens around the country who believe the U.S. would benefit - socially, environmentally, and economically - from a planned, voluntary end to continued population growth. In our advocacy of the importance of family planning and the availability of voluntary contraceptive services, we have repeatedly called attention to the comparatively high rates of adolescent fertility and the serious health, educational, and economic problems associated with adolescent parenthood.

These problems have been well documented in research, publications, and testimony to Congressional committees in recent years.[1] For that reason, we believe it is the adequacy of S. 2910, not the problem of adolescent pregnancy itself nor the need for legislation, which is the critical issue in assessing the Administration's proposal. "Is S. 2910 a sufficiently constructive and clearly defined legislative response to the problem of adolescent pregnancy?" We believe it is not, and it should be revised.

Inadequacies of S. 2910

The bill is vague in defining its relationship to existing federal programs, the population it seeks to serve, the objectives it seeks to achieve, and the priorities it sets for funding:

1. Relationship to other programs. Although the Administration has emphasized the importance of linkage and coordination of programs, S. 2910 does not define its relationship to existing federal programs which provide support for services to adolescents or have the potential for service support.

2. Target population. The bill seeks to serve, without making any distinction among them, not only an enormous population - 21 million teenagers ages 15 to 19 and 40 million ages 10 to 19 - but also an enormously diverse population: girls and boys; sexually experienced and sexually inexperienced individuals; youths who are still children and others who are really adults; and pregnant girls and young parents, some with more than one child.

3. Objectives. The bill establishes for HEW a set of broad and not easily measured objectives: pregnancy prevention, care for pregnant adolescents, and help for adolescents to become "productive independent contributors to family and community life".

4. Funding priorities. The bill offers support for an extensive range of services which are often expensive to provide and do not exist in many communities.[2] Yet, it sets as priorities for funding only comprehensiveness, coordination, and service support in communities with a high incidence of adolescent pregnancy and low incomes.

As a result of its vagueness - its all-encompassing scope - S. 2910 would give HEW inadequate direction for the use of the limited resources it would authorize. The estimated costs of the services that would be eligible for funding only emphasize the inadequacy of direction for resource allocation.

For example, the costs of serving already pregnant teenagers alone would be considerable. Of the one million girls ages 15 to 19 who are estimated to become pregnant annually, 600,000 give birth and close to 90 percent keep their infants. According to HEW Secretary Joseph Califano in his oral testimony to your Committee on June 14, the costs of services per pregnant adolescent girl under this bill are estimated to be an average of $750. This does not include the costs of the infant's delivery.

According to Dr. Janet Hardy, Director of Johns Hopkins University Center for School-Age Mothers and their Infants (cited by HEW as a model program), in oral comments to the House Select Committee on Population on March 2, the estimated annual cost of comprehensive services per pregnant girl under her program is $2000, not including Medicaid/Medicare coverage for obstetrical services. Long term provision of a complete range of services for mother and child might cost an estimated $5000 annually.

In other words, if HEW were to seek only to provide services for the 600,000 pregnant girls who deliver annually, the costs might range from $450 million to $3 billion just using these estimates. Clearly, both the $60 million proposed under S. 2910 and the $340 million HEW has requested for its entire package of adolescent pregnancy initiatives in fiscal 1979[3] fall far short in comparison. In ZPG's opinion, the bill does not give HEW either specific objectives or sufficient priorities to guide the use of the proposed funding.

Importance of Title X

The focus of the bill should be determined both by complementary federal programs already in place and the language of the legislation itself. We believe it is no longer useful to evaluate this need for direction in the context of the Administration's $340 million budget request. One must also consider the changes Congress already has begun to make in that request.

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This Committee, the full Senate, and the Interstate and Foreign Commerce Committee in the House have recommended substantial and long-term increases in funding under Title X of the Public Health Service Act, the major single source of federal funding for family planning services,[4] with a special emphasis on serving teenagers. In the history of Title X, these actions represent steps toward a major new commitment to the voluntary prevention of unwanted births - a commitment family planning supporters have advocated for several years.

ZPG specifically endorses the funding levels and range of Title X services approved by the Senate in S. 2252, which includes earmarked funding for programs serving adolescents. The wisdom of such an escalated federal investment in the prevention of adolescent pregnancies is borne out by the most recently published analyses of data on adolescent contraceptive use and premarital pregnancy.

Looking at nationwide survey data collected in 1976, researchers in the Department of Population Dynamics at Johns Hopkins University found a "strong negative correlation between contraceptive use and continuity of use and (adolescent) pregnancy; Fifty-eight percent of never users experienced a premarital pregnancy, compared to 24 percent of sometime users and only 11 percent of always users."[5] Today, of the estimated four million sexually active teenage girls ages 15 to 19, more than a million and a half still do not have access to medically prescribed contraceptive services.[6]

In responding to the problem of adolescent pregnancy, Congress should adopt the Title X provisions of S.2252 passed by the Senate, and revise S. 2910 to build on this commitment to family planning services and education for all, including adolescents. S. 2910 should be revised clearly so that it begins to support more comprehensive services to meet the problems of pregnant adolescents and adolescent parents, who often experience additional and repeated unwanted pregnancies.[7] According to current research, a quarter of teenage mothers, including married girls, experience a second pregnancy within one year of their first delivery.[8]

Recommended Revisions in H.R. 12246

Four general changes in the bill would give it the direction it needs for such a goal - a goal which we believe is already inherent in HEW's initiatives:

1. RELATIONSHIP TO TITLE X. The "Findings and Purposes" section should be rewritten to state explicitly Congress' commitment to supporting family planning services under Title X of the Public Health Service Act and its intention that adolescent

pregnancy-related services funded under this Act should build on, not duplicate that program's efforts.

2. TARGET POPULATION AND OBJECTIVES. While recognizing the number and variety of adolescents in need of different kinds of services, this bill should specify as its target population adolescents who are pregnant, adolescent parents, and their personal friends or relatives. As its objectives in serving those adolescents, the bill should seek to improve their health and their children's health, reduce the likelihood of repeat unwanted pregnancies, and improve their chances of completing their schooling and becoming self-supporting.[10]

3. PRIORITIES FOR SERVICES. The bill should require applicants for funding to demonstrate the availability of a minimum core of services for early pregnancy detection, pregnancy options counseling, pre- and post- natal care, and family planning counseling and services in order to qualify for a broader range of educational, social, and economic services.[11]

4. EVALUATION FUNDING. Because of the dearth of research on the effectiveness of programs dealing with adolescent pregnancy, the bill in Sec. 201 (c) should provide three percent of the funding instead of one percent for evaluation. In the report accompanying its approved bill, the Committee should spell out its expectations for evaluation of nationwide trends, duplication of model programs, and innovative or experimental projects.

If S. 2910 were given the clearly defined objectives and priorities these kinds of changes would accomplish, we believe it would be appropriate for the Human Resources Committee then to consider additional refining amendments which would further strengthen the bill.

1. FUNDING LEVELS. Adolescent pregnancy is an ongoing problem with long-term effects. It will require an equally long-term response which should be demonstrated by earmarking funding for the second and third years authorized by the bill. ZPG supports authorizations of at least $90 million for the second fiscal year and $120 million for the third.

2. CEILING ON SERVICES FUNDING. Different studies by the National Alliance Concerned with School-Age Parents and researchers with the School of Public Health at the University of California, Berkeley, indicate that the major service problem in many communities is not the lack of coordination or linkage but lack or services themselves.[12] Therefore, ZPG recommends that Sec. 102(e)'s 50 percent ceiling on funding of services be increased to 75 percent.

3. MAINTENANCE OF EFFORT. Because of the need to build on existing resources -- not only federal but also state and local- the bill should include a "maintenance of effort" requirement in a new Sec. 102(f).[13]

4. ADVISORY COMMITTEE. Because of the complexity of the problems associated with adolescent pregnancy and the interest in encouraging innovative programs under this legislation, a new Sec. 201(a)(6) should be added to the bill to establish a multi-disciplinary advisory committee to advise HEW on rulemaking and evaluation requirements.[14]

5. ROLE OF THE DASPA. ZPG believes adolescent pregnancy is one of the most critical population problems facing HEW today. Departmental programs to respond to it should be coordinated under the Deputy Assistant Secretary for Population Affairs, a position mandated by Congress in the 1970 "Family Planning Services and Population Research Act," but temporarily eliminated as a full-time position by HEW last year. We recommend that the Committee express its interest in seeing coordination of the adolescent pregnancy initiatives under the DASPA in communications with the Department and in report language.

Conclusion

In conclusion, ZPG believes the issues facing the Committee are not whether there is an adolescent pregnancy problem but whether S. 2910 is adequate to deal with the problem; not whether comprehensive services should be provided under the bill but what is the bill's relationship to Title X of the Public Health Service Act and its funding priorities for services.

The legislative changes ZPG has proposed speak to those issues, and we have spelled them out in more detail in specific re-writings of the bill which we would be happy to share with the Committee and its staff.

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FOOTNOTES

1 The research findings on the health, education, economic and social problems of adolescent pregnancy are summarized in the attached ZPG publication, "Teenage Pregnancy: A Major Problem for Minors."

2 In their study, "Services for and Needs of Pregnant Teenagers in Large Cities of the United States," (PUBLIC HEALTH REPORTS - January/February 1978), Hyman Goldstein and Helen M. Wallace of the University of California at Berkeley, found that only one in five of all pregnant adolescents needing special programs are accommodated under existing services. Janet Bell Forbush, Executive Director of the National Alliance Concerned with School-Age Parents, found in a survey of service providers around the country a "patchwork quilt" of services, which often would benefit more from their expansion than their co-ordination.

3 In its fiscal 1979 budget request, the Department of Health, Education and Welfare requested $338 million for new and existing programs to deal with the problems of adolescent pregnancy. It represented a $142 million increase over fiscal 1978. However, the only increase earmarked exclusively for family planning was $18 million under Title X of the Public Health Service Act. And that represented only $8 million in new monies and $10 million transferred from programs serving older women. In addition to this funding and the $60 million in new legislative authority, the Administration also requested increased monies under Medicaid and Title XX social service program reimbursements under the Social Security Act, maternal and child health care under Title V of the SSA, community health centers, health education, and research and training.

4 H.R. 12370, the "Health Services Amendments of 1978" reported out of the House Interstate and Foreign Commerce Committee in May would increase Title X funding for family planning service project grants from $135 million in fiscal 1979 and additional increases leading to $264.5 million in fiscal 1981. The report accompanying the bill emphasizes serving teenagers. On June 7, the Senate passed S. 2252, the Voluntary Family Planning Services, Population Research, and Sudden Infant Death Syndrome Amendments of 1978." It would provide $216.5 million for project grants in fiscal 1979 increasing to $598 million in fiscal 1978. The Senate bill also would authorize several million dollars for education and materials which the House bill does not provide.

5 Melvin Zelnik and John Kantner of the Department of Population Dynamics of Johns Hopkins University report on "Contraceptive Patterns and Premarital Pregnancy Among Women Aged 15-19 in 1976" in the May/June issue of FAMILY PLANNING PERSPECTIVES.

According to their research, six percent of sexually active women using a medical method of contraception regularly risk pregnancy, 11 percent who use some form of contraception regularly, and 58 percent who never use contraception. It is estimated that if adolescents did not now use contraception, an additional 680,000 girls would experience premarital pregnancies annually, increaseing the annual total to 1.46 million.

6 According to the Alan Guttmacher Institute, the research and policy affiliate of the Planned Parenthood Federation of America, in its May 1978 report "Contraceptive Services for Adolescents: United States, Each State and County, 1975," six out of ten sexually active adolescent girls agea 15-19 did not have access to medically prescribed contraceptives in 1975. Of the four million sexually active girls in this age range, 1.2 million received services from organized clinics and 1.2 million received services from private physicians.

7 In a study of pregnant adolescents and their classmates in Baltimore from 1968 to 1972, Frank Furstenburg of the Center for Population Research at the University of Pennsylvania found a substantial gap between the family size expectations and the actual family size of young women who became pregnant as teenagers. On the average, adolescent mothers in this inner city study foresaw much smaller families than they later had within just five years." (FAMILY PLANNING PERSPECTIVES, July/August 1976), Furstenburg reported that within five uears of delivery of their first child, 30 percent of the adolescent mothers in the study had become pregnant again at least twice.

8 In 1978, Furstenburg (see #7) stated that most published studies show that at least one-half of adolescent mothers experience a second pregnancy within 36 months of delivery. According to Kantner and Zelnik (see #5), based on their research, 25.6 percent of adolescent mothers, including married girls, become pregnant within one year of their first birth. Larry Bumpass of the Center for Demography and Ecology at the University of Wisconsin in "Age and Marital Status at First Birth and the Pace of Subsequent Fertiliy," DEMOGRAPHY, February 1978, found a significant relationship between shorter birth intervals and earlier age at first birth. In its report, "11 Million Teenagers," the Alan Guttmacher Institute stated that married women who begin childbearing before they are 18 will have families 1.3 times larger than women who begin to have children at ages 20 to 24. The younger women expect a completed family of nearly four children compared to the family size expectation of less than three children among older women.

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9 ZPG recommends a new Sec. 2(a)(7) and (8) to specify the relationship of S. 2910 to Title X: "(7) the Federal government has begun to provide support for family planning services for adolescents under Title X of the Public Health Service Act and to a lesser extent under Titles V,XIX, and XX of the Social Security Act; and (8) therefore, federal policy should continue and expand support for family planning services under Title X of the PHSA and Titles V,XIX, and XX under the PHSA while providing support under this Act for comprehensive services for pregnant adolescents, adolescent parents and their immediate friends or relatives.

10 ZPG recommends rewriting Sec. 2(b) to read: (b) It is, therefore the purpose of this Act -

(1) to support the linkage, expansion, improvement and creation of comprehensive, community-based services for pregnant adolescents and adolescent parents:
(A) have options about pregnancy and childbirth,
(B) have improved health for themselves and their infants, and
(C) experience fewer unintended repeat pregnancies;

(2) to support, in supplement to these core services, other educational, social, and health services which will help the target population:
(A) complete schooling,
(B) improve vocational opportunities, and
(C) reduce future welfare dependence; and

(3) to support , in supplement to these core services, additional services or referral to services to assist the friends and relatives brought into programs serving pregnant adolescents and adolescent parents to prevent initial unwanted pregnancies.

(At the Johns Hopkins Center for School-Age Mothers, participants in the program are encouraged to bring friends or relatives with them to classes and counseling sessions; more than half do.)

11 ZPG's reasons for giving top priority to these services are:

a) Early pregnancy detection is essential to begin prenatal care during the first trimester of pregnancy as well as to enable girls to consider the option of abortion when it is safest to their health. According to the Goldstein/Wallace survey of special services in large urban areas for adolescents (see #2) only 45 percent provide pregnancy testing.

b) Pregnancy options counseling should give the pregnant

adolescent the objective information she needs to make a decision about the options open to her: to deliver and keep her infant, to deliver and place her infant for adoption, or to obtain an abortion. When she has information about all of these options, then the girl can make her own decision.

c) Not only pre-natal health care, but also long-term post-natal health care are associated with reduced risk of mortality, and improved health for both mother and infant.

d) The Goldstein/Wallace study (see #2) found that ten other services are provided more frequently than contraception and five others are provided more frequently than sex education in special programs serving pregnant adolescents. Fifty-nine percent of the special programs reported by respondents to the survey provide contraceptive services.

12 As mentioned in #2, research indicates that shortage of services, not lack of service coordination, is the major problem in reaching adolescents.

13 ZPG recommends the addition of a "maintenance of effort" clause in a new Sec. 102(f): "These funds may not be used to replace funds currently being used either to provide direct services or to link services.".

14 ZPG recommends the addition of a new Sec. 201(a)(6): "(6) appoint a multi-disciplinary advisory committee, of no more than 20 people, which shall be composed primarily of persons experienced in providing services to sexually active youth and pregnant adolescents and adolescent parents. Other advisory committee members shall come from organizations and agencies having experience in such areas as policy-making and research as well as consumer services. The functions of the advisory committee shall include, but not be limited to, a consultive role in the development of regulations and of overall evaluation criteria."

Teenage Pregnancy:

ZERO POPULATION GROWTH

A Major Problem for Minors

Teenage pregnancy has reached epidemic proportions in the United States. Each year, more than one million teenagers become pregnant. In comparison, 24,374 Americans contracted measles and 59,647 had mumps in 1975, the most recent year for which statistics are available. By the age of 20, three in 10 American women have borne at least one child.

Early childbearing poses serious health, social, and economic consequences for teenage mothers and their children. In addition to facing higher health risks both for themselves and their children, teenage mothers are often forced to leave school and to forego job training and other opportunities for economic advancement. Unmarried mothers face social disapproval, financial hardship, and difficulty in finding work and child care facilities. If they marry, teenage mothers are more likely to have unstable marriages and financial problems than others of the same age and socio-economic status. Women who have their first child in their teen years tend to have more children in quicker succession than their peers.

In the past, pregnant teenagers were pressured to get married or have their babies secretly and put them up for adoption. In addition, they were routinely expelled from school. Today teen mothers are asserting their right to an education, and special classes and programs have been started in many communities.

While older women's fertility has been declining during the past five years, teenagers aged 14 and younger have had increasing numbers of children, and the fertility rate of teens aged 15-16 has remained about the same. The proportion of U.S. births attributed to teenagers has been increasing; one in five U.S. births is to a teenager. Also, the number of out-of-wedlock births to teenagers is rising; teenagers account for half of all out-of-wedlock births in the United States. Most teenage pregnancies are unwanted, as is indicated by the fact that one in three U.S. abortions is to a teenager.

Experts attribute the epidemic of teenage pregnancies to increased sexual activity, non-use or ineffective use of contraceptives, and lack of contraceptive information and services for teenagers. More than four million teenage women aged 15-19 are sexually active and at risk of unwanted pregnancy. Only half of them are currently receiving contraceptive services. Of the estimated 420,000 to 630,000 teenage females under 15 who are sexually active, only 7 percent are receiving contraceptive services even though this age group is most vulnerable to health risks if they become pregnant.

Studies show that most teenagers seek contraceptive services after they have become sexually active; many of them come to clinics initially for pregnancy tests. Traditional sanctions against premarital sex have not kept teenagers celibate but rather appear to have contributed to the non-use and sporadic use of contraceptives as well as the tendency to select unreliable contraceptive methods.

Teenage Pregnancy—An Overview

Births to Teenagers

- Teenagers bear nearly one in five babies born in the United States; two-fifths of these births are out of wedlock and account for half the total out-of-wedlock births in the country.
- Three in 10 women aged 20 in 1975 had borne at least one child.

Pregnancy

- One in six teenage women who have premarital intercourse becomes pregnant.
- One in 10 teenage women aged 15-19 becomes pregnant each year.
- Six in 10 teenage pregnancies end in live births, nearly three in 10 are terminated by abortion, and one in 10 ends in miscarriage.
- Teenagers account for one-third of all legal abortions performed in the United States.

Health Risks

- The death rate from complications of pregnancy and childbirth is 13 percent greater for 15-19-year-olds and 60 percent greater for teenagers 14 or younger compared with women in their early 20's.
- Babies born to teenagers are two to three times more likely to die in their first year than babies born to women in their early 20's.

Contraception

- Only three in 10 sexually-active teenage women use contraception consistently.
- Among sexually-active teenage women who do not use contraceptives, seven in 10 think that they cannot become pregnant.
- The condom, withdrawal, and the Pill account for more than three-fourths of all contraceptive use among teenagers.
- Half of all sexually-active teenage women (about two million) are still not receiving family planning services from clinics or private physicians.

Teen Sexual Activity Increasing

More than half of the 21 million young people aged 15-19 are estimated to be sexually experienced—almost seven million young men and four million women. In addition, about one-fifth of the eight million 13-14-year-olds have had sex. A 1976 national survey confirmed that a growing proportion of teenagers are sexually active and that they are beginning their sexual activity at earlier ages. The study found that 35 percent of the single female teenagers had experienced intercourse in 1976 compared with 27 percent in 1971—a 30 percent increase. The proportion of sexually-experienced females rises from 18 percent at age 15 to 55 percent at age 19.

Most studies indicate that teenage sexual activity is sporadic. The 1976 study found that nearly half of the sexually experienced teenagers surveyed had not had intercourse in the month prior to the survey. The proportion of sexually experienced blacks (63%) is twice that of whites (31%), the survey found, but the rate of increase for whites from 1971 to 1976 is more than twice the rate for blacks.

Along with increasing sexual experience, teenagers are also contracting venereal diseases in growing numbers. Teenagers aged 15-19 are three times more likely to contract gonorrhea than people over 20, while the risk of syphilis is 61 percent greater for teenagers.

Many Teens Risk Pregnancy

Few teenagers begin to use contraception at the same time that they begin having sexual intercourse, and their contraceptive use is typically sporadic. A 1975 study in four cities found that almost half of the sexually-active females and nearly 70 percent of the males surveyed risked pregnancy at least once. A national survey of teenage contraceptive practice revealed that the sexually-active single teenage women who had never used contraception had increased from 17 percent in 1971 to 28 percent in 1976.

Nevertheless, the 1976 survey also found that those teenagers who do use contraceptives select more effective methods today than in 1971. The study found that nearly two-thirds (64%) of the single teenage women interviewed had used birth control at last intercourse, and one-third of them had used the Pill or IUD. Three in 10 said they "always" used contraception. The Pill was named the "most recently used" method by 47 percent of the teenage women using contraception, while 21 percent used the condom, 17 percent used withdrawal, 8 percent used foam, cream, diaphragm, or rhythm, 4 percent used douche, and 3 percent had an IUD.

Many teenagers who do not use birth control are poorly informed about the risks of pregnancy. According to a 1971 national survey, seven in 10 of the single teenage women who did not use birth control explained that they thought they had sex too infrequently or that they had intercourse at the "safe time of the month." Ironically, only 38 percent of the teenagers surveyed could identify the time of the menstrual cycle when pregnancy is most likely to occur.

Citing other reasons for contraceptive non-use, 31 percent of the respondents said that they could not obtain contraceptive services, 24 percent explained that contraceptives interfered with the pleasure or spontaneity of sex, and 13 percent mentioned moral or medical objections to contraceptives (Respondents gave more than one answer.). Nevertheless, eight out of 10 (64%) of the non-users said that they did not wish to become pregnant.

Research studies have found no evidence that the availability of abortion would weaken the motivation to use contraception. In a 1971 study, sexually-experienced teenage women were asked what they thought a young unmarried girl should do if she finds herself pregnant by a boy she does not love; only one in five chose the option of abortion.

Clinic Services for Teens Inadequate

Between 1971 and 1975, the number of teenagers on family planning clinic rosters more than doubled. Nevertheless, many teenagers are still unable to obtain clinic services and many programs fail to reach teenagers early enough. One study of 40 family planning clinics found that 94 percent of the teenage patients had had sexual intercourse before seeking contraceptive services, and 75 percent had been sexually active for at least a year. Thirty percent of the teenagers had been pregnant previously.

In 1975, there were 1.1 million teenage women enrolled in organized family planning programs, constituting 30 percent of the national clinic caseload. Nearly half of the adolescent patients had never used contraception prior to enrollment. After enrollment, 84 percent used the most effective methods—the Pill or the IUD. An additional 850,000-1,000,000 teenage women receive contraception from private physicians. However, about half of the four million sexually-active females aged 15-19 are still not receiving family planning help from any source. A meager seven percent of the sexually-active teens younger than 15 are currently receiving family planning services.

Pregnancy among Teenagers

Planned Parenthood's Alan Guttmacher Institute (AGI) estimates that each year more than one million teenagers aged 15-19 become pregnant—one in 10 of the females in this age group. In addition, 30,000 girls younger than 15 get pregnant annually. More than two-thirds of all teenage pregnancies are believed to be unintended.

Of the million pregnancies which occurred in 1974, 28 percent resulted in marital births that were conceived following marriage, 27 percent were terminated by abortion, 21 percent resulted in out-of-wedlock births, 14 percent ended in miscarriage, and 10 percent resulted in marital births that were conceived prior to marriage.

Among pregnant adolescents 14 and younger, 45 percent have abortions, about 38 percent give birth out of wedlock, and 13 percent miscarry. Only 6 percent of these young teenage pregnancies end in marital births.

Teens Have One-third of U.S. Abortions

Teenagers account for about one-third of all legal abortions—an estimated 325,000 abortions in 1975. In 1974, three in 10 teenage pregnancies were terminated by abortion. About half of all teenage abortions were obtained by 18- and 19-year-olds, 45 percent by 15-17-year-olds, and 5 percent by girls 14 and younger. Between 1972 and 1975, the abortion rate rose from 19 to 31 procedures per 1,000 women under age 20. Increased availability of abortion has slowed the rise in out-of-wedlock births which began in the late 1960's, but it has not reversed the trend.

Legal abortion is still not equally available throughout the country. Abortion services tend to be concentrated in one or two metropolitan areas in each state. The need to travel outside one's community is a hardship for young and poor women who often can't afford such a trip. The unequal distribution of abortion services is evident in the varying abortion ratios for teenagers in different states, ranging from three abortions per 1,000 live births in Mississippi to 1,300 per 1,000 births in New York. The Alan Guttmacher Institute estimates that a minimum of 125,000 teenagers were unable to obtain needed abortion services in 1975.

Childbearing among Teenagers

In 1975, nearly one in five (19%) of all births in the United States was to a teenager—12,642 births to women under 15 and 582,238 to women aged 15-19. Fertility rates for older teenagers have fallen slightly in recent years, though not as sharply as the declines among women aged 20 and older. Births to girls younger than 14 have increased, while fertility among young women aged 14-17 has remained at approximately the same level. Between 1974 and 1975, the fertility rate for girls aged 10-14 increased by 8 percent.

The proportion of teenagers giving birth rises rapidly with age. The National Center for Health Statistics calculated that in 1975 nearly 1 percent of the 15-year-olds had had at least one child, 3 percent of the 16-year-olds, 6 percent of the 17-year-olds, 12 percent of the 18-year-olds, 20 percent of the 19-year-olds, and 30 percent of the 20-year-olds. Teenagers tend to have their children in quick succession. In 1975, nearly one-fourth (24%) of mothers aged 20 had had more than one child; 21 percent of all births to teenagers were second or higher order births.

Nearly two in five (39%) of all births to teenagers are out-of-wedlock, and the proportion of births to unmarried teens is increasing. With the decline in marital fertility there has been a corresponding increase in childbearing outside of marriage for both white and black teenagers. In 1975, one in five babies born to white teenagers and three in four babies born to black teenagers were out-of-wedlock. Over half (52%) of the out-of-wedlock births in 1975 were to teenagers—11,000 to women under 15 and 222,500 to women aged 15-19, a 5 percent increase over the previous year. Among those teenagers who give birth out of wedlock, 87 percent keep the child, 5 percent send the baby to live with others, and 8 percent give the baby up for adoption.

Teen Mothers Run Health Risk

Both the adolescent who gives birth and her infant face greater risk of death, illness, or injury than do women in their 20's. The maternal death rate is 60 percent higher for teenagers aged 14 or younger and 13 percent greater for 15-19-year-olds than for women in their early 20's. Women giving birth at ages 15-19 are twice as likely to die from hemorrhage and miscarriage and 1.5 times more likely to die from toxemia (blood poisoning) than mothers in their early 20's. The risks increase dramatically for women under 15 giving birth; they are 3.5 times more likely to die from toxemia. Although the health risks for younger teenagers are considerably higher than those for women aged 18-19, the risks generally increase with parity, so that an 18-year-old experiencing a second pregnancy may have dramatically increased health risks.

The most common complications of teenage pregnancy are toxemia, prolonged labor and iron-deficiency anemia. Poor nutrition, inadequate prenatal care, and physical immaturity contribute to the risk of complications.

Children born to teenage mothers are two to three times more likely to die in their first year than babies born to women in their 20's. About 6 percent of first babies born to girls under 15 die in their first year. The incidence of prematurity and low birth weight is higher among teenage pregnancies, increasing the risk of such conditions as epilepsy, cerebral palsy, and mental retardation.

Life Options for Young Parents

Education: Pregnancy and motherhood are the major causes of young women leaving school. Eight out of 10 women who become pregnant at 17 or younger never complete high school. Among teenage mothers 15 and younger, nine in 10 never complete high school and four in 10 fail to complete even the eighth grade. Despite legislation and court decisions upholding the right of school-age parents to education, the drop-out statistics suggest that many schools' policies and personnel may discourage pregnant students from continuing their schooling.

Employment and Economic Opportunity: Because many young mothers do not complete high school and the vast majority (79% in a New York City study) have no work experience, adolescent mothers are doubly disadvantaged in competing for jobs. Childcare responsibilities often further restrict employment opportunities. Teenage mothers are more likely to be unemployed and to receive welfare than mothers who postpone their childbearing until their 20's. The New York City study of teenage mothers found that 91 percent of the women who gave birth at ages 15-17 were unemployed a year and a half after the birth and 72 percent were receiving welfare assistance. Even 18- and 19-year-old mothers were slightly more likely than older mothers to be unemployed and two and a half times more likely to be on public assistance.

Marital Prospects: Teenage marriages are two to three times more likely to break up, compared with those who marry in their 20's. Teenage couples who marry as a result of pregnancy are more likely to be economically disadvantaged in terms of occupation, income, and assets than are couples of similar socio-economic status. Such marriages are also more vulnerable to divorce and separation. A Baltimore study of premaritally pregnant teenage couples (17 or younger) found that one-fifth of the marriages broke up within one year and nearly one-third dissolved within two years. Within six years, three in five of the couples were divorced or separated.

Family Size: Women who give birth as teenagers tend to have a larger completed family size and tend to have their children closer together. Married women who have their first child at age 17 or younger expect a completed family of four, while wives whose first birth comes at the ages of 20-24 expect fewer than three children. Women who have their first child at age 17 or younger will have 30 percent more children than women who begin childbearing at ages 20-24, and women aged 18-19 at first birth will have 10 percent larger families.

Laws Regarding Minors

During the last five years, there has been a clear trend toward liberalizing laws regarding the right of minors to consent to their own medical care. Currently, 26 states and the District of Columbia specifically affirm the right of minors to consent to contraceptive care, and all 50 states allow minors to consent to venereal disease treatment. In July 1976, the U.S. Supreme Court overruled a Missouri law which required a minor to have parental consent to obtain an abortion, thus invalidating similar laws in 26 states. Earlier in 1976, the Supreme Court ruled that Federally-funded family planning programs must serve eligible minors on their own consent.

Despite this liberal trend and despite the fact that no physician has been held liable for providing contraceptive services to minors of any age, many agencies and physicians still refuse fertility control services to minors without written parental permission.

The right of minors to purchase non-prescription contraceptives was upheld by the U.S. Supreme Court in a June 1977 decision. The Supreme Court invalidated a New York law which banned the sale of non-prescription contraceptives to persons under 16.

Teens Denied Information

Despite evidence from several studies that one of the major causes of unwanted teenage pregnancy is ignorance about human reproduction and the risk of pregnancy, young people continue to be denied the information they need to make responsible decisions related to their sexuality.

Research suggests that mass media, especially television and radio, are an important source of family planning information for teenagers. A 1974 family planning communication study found that mass media contributed more to teenagers' family planning knowledge than other sources, including parents, peers, or schools. However, the researchers' analysis of media coverage revealed that television and radio provided very little contraceptive information: television contained an average of only eight minutes of family planning-related programming in an entire month, while radio broadcast an average of 14 minutes monthly. Newspapers contained only 19 items during the month.

Contraceptive advertising on television and radio is banned by the Code Authority of the National Association of Broadcasters, thereby eliminating another potential source of information about contraceptives.

At present, only 29 states and the District of Columbia require the teaching of health education in public high schools, and only six of these states and the District mandate family life or sex education as part of the curriculum. While Louisiana is the only state which outlaws sex education altogether, both Michigan and Louisiana specifically prohibit teaching about contraception.

Many states officially "encourage" the teaching of these subjects in their education policies but allow for local options. Consequently, hundreds of school districts have ignored, restricted, or prohibited sex education.

Even where sex education is provided in schools, contraception is often not discussed. A 1970 survey of U.S. school districts revealed that only two in five sex education teachers included contraception in their curricula. Human reproduction, adolescent development, and venereal disease were the most commonly covered topics. A recent national survey of high school teachers in population-related subject areas found that only one-third taught anything about human reproduction, sexuality or abortion. Even fewer taught about birth control.

The Job to Be Done

A report submitted in 1976 to the Department of Health, Education and Welfare by Urban and Rural Systems Associates recommends that sexually-active teenagers be designated a high priority target population for family planning services and that Federal and state funding for family planning services be increased. To increase clinic attendance, the report encourages the establishment of separate teen clinics with sensitive staffs and low-cost, confidential treatment. State laws and policies which restrict teenage patients in consenting to their own contraceptive care should be modified, the report notes.

Additional recommendations for a national program to deal with the problems of adolescent childbearing were issued by the Alan Guttmacher Institute in 1978. Its recommendations include

- Realistic sex education via school, churches, and mass media, including information about pregnancy risks, contraception, and abortion and places where teenagers can obtain these services.
- For pregnant teens, adequate pregnancy counseling with non-judgmental information on all available options, including abortion referral.
- Adequate prenatal, obstetrical and pediatric care for teenagers who carry their pregnancy to term in order to minimize the hazards of early childbearing for both mother and child.
- Educational, employment, and social services for adolescent parents and day care for their infants to help teenagers realize their educational and career goals.
- National health insurance coverage for all health services related to adolescent pregnancy and childbearing with provisions to protect the privacy of minors.
- Expansion of biomedical research to discover new, safe and effective methods of contraception more suited to the needs of young men and women.

Much more work needs to be done to educate teenagers and their parents on the problems related to teenage pregnancy and the availability of contraceptive information, counseling, and services. In addition, school authorities, social workers, and health personnel, especially physicians, must be made aware of the special needs of teenagers.

Teenage pregnancy is a complicated problem which will be with us for some time to come. Failing to act today only compounds the high human, social, and economic costs to be borne by teenage mothers, their children, and society in general.

Public Savings

Pregnancy prevention programs are highly cost-effective in saving future government expenditures to support out-of-wedlock children and their mothers. The Planned Parenthood Federation of America estimates that every dollar spent in one year on family planning saves two dollars in the following year alone and many times the original expenditure in the long-term. The California Department of Public Health calculated that if only 20 percent of eligible minors used contraceptive services and only 10 percent of teenage pregnancies were prevented, the net savings to the state would be $2.3 million in the first year.

Suggested Reading

- 11 Million Teenagers: What Can Be Done About the Epidemic of Adolescent Pregnancies in the United States. 64 pages. $2.50. Available from The Alan Guttmacher Institute, 515 Madison Ave., New York, N.Y. 10022.
- Adolescent Pregnancy and Childbearing: Growing Concerns for Americans, by Wendy H. Baldwin. Population Bulletin. Vol. 31, No. 2. 36 pages. 75¢. Available from Population Reference Bureau, 1337 Connecticut Ave. N.W., Washington, D.C. 20036.
- Sex Education Action/Resource Bulletin. 4 pages. Free. Available from The Population Institute, 110 Maryland Ave. N.W., Washington, D.C. 20002.
- Sex and Birth Control: A Guide for the Young, by E. James Lieberman and Ellen Peck. 299 pages. $2.45 paper. (New York: Schocken Books, 1975.)
- Sex, by Sol Gordon with Roger Conant. 142 pages. $8.95 paper. (New York: Quadrangle/The New York Times Book Co., 1975.)
- Improving Family Planning Services for Teenagers, by Urban and Rural Systems Associates. 34 pages. Free. Available from Ms. Clara Schiffer, Office of Planning and Evaluation, Dept. of Health, Education and Welfare, South Portal Bldg., 4th Floor, 330 Independence Ave. S.W., Washington, D.C. 20201.

Prepared by Cynthia P. Green and Kate Pottinger.

Additional copies of *Teenage Pregnancy: A Major Problem for Minors* are available from Zero Population Growth, 1346 Connecticut Ave. N.W., Washington, D.C. 20036. Single copies free, 2-49 copies, 12¢ each; 50-199, 11¢ each; 200-499, 9.5¢ each; 500 or more, 8.5¢ each. For data and information sources, write to ZPG.

Zero Population Growth, Inc. is a national membership organization which advocates U.S. and world population stabilization. ZPG's lobbying and public education programs address a wide range of issues, including population growth, family size, immigration, teenage pregnancy, abortion, and national growth policy. ZPG welcomes inquiries regarding membership and provides a free publications list upon request.

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ASSOCIATES FOR RENEWAL IN EDUCATION, INC./1101 FIFTEENTH ST., N.W. SUITE LL-80/WASHINGTON D.C. 20005/(202)331-1707

TESTIMONY

OF

ASSOCIATES FOR RENEWAL IN EDUCATION, INC.

ON

S. 2910

Adolescent Health Services and Pregnancy Prevention and Care Act of 1978

Submitted to:

Human Resources Committee

U.S. Senate

Submitted by:

Lana D. Smith
Director, Parent Focus
Associates for Renewal in Education, Inc.

July 24, 1978

Associates for Renewal in Education, Inc. is a private non-profit organization, committed to the improvement of education and the delivery of human services in The District of Columbia. Associates for Renewal in Education, Inc. believes that linkage of services and inter-agency cooperation is a key to the development of comprehensive approaches to the solution of social problems. As the attached Statement of Capability bears out, Associates for Renewal in Education, Inc. has, since its inception in 1971, facilitated and implemented many educational efforts in the District of Columbia in close cooperation with the District of Columbia Public Schools, District of Columbia Department of Human Resources, and other local public and private agencies, aimed at improving the quality of education of children and youth within the realm of the schools, the community, and the home.

Since 1976, one of Associates for Renewal in Education, Inc.'s projects, Parent Focus, has been dedicated to meeting the multi-disciplinary needs of school-age parents and their children in the District of Columbia where services to pregnant adolescents and adolescent mothers have been haphazard, scattered, and often non-existent since the close, in 1972, of the federally funded Webster School for Girls.

Statistics bear out the District of Columbia's critical need for health, educational, and social services to adolescents at risk of pregnancy, pregnant adolescents and adolescent parents and their families. In 1977, one out of every four live births was to a

teenager. Teenagers account for the majority of out-of-wedlock births and for the majority of abortions. The District of Columbia has a long history of high maternal and infant mortality. In 1976, the District's infant mortality rate (26) was the highest in the country both as a city and as a state. It remains almost twice as high as the national rate (14).

In the District of Columbia where 1 out of every 3 women 15-19 years old becomes pregnant, Parent Focus has developed the following, in close cooperation with the District of Columbia Public Schools:

1. The S.T.A.Y. (School-To-Aid-Youth) Parent-Child Center for adolescent parents and their children. S.T.A.Y. is an alternative District of Columbia Public School with city-wide enrollment. The Parent-Child Center offers a comprehensive parenting program including courses in parenting and child growth and development, and nutrition, child care through an infant nursery and a pre-school center, and rap sessions for parents and non-parents. Its unique feature is that it was conceived, designed, and is operated with the full participation of young parents resulting in an on-going involvement of young fathers and young mothers.

2. A parenting curriculum designed specifically for teenage parents.

3. The only existing staff development curriculum designed for training District of Columbia Public Schools personnel who work with expectant teenagers or teenage parents; The

curriculum focuses on improving school personnel communication skills with young people on the issue of sexuality and on linking the adolescent to existing neighborhood and community services.

In the process of developing these training programs and the S.T.A.Y. Parent-Child Center, Parent Focus has become deeply aware of the necessity to link educational, health, and social services at the community level in meeting the complex needs of adolescents at risk of pregnancy, pregnant adolescents and adolescent parents, their children, and families.

In an effort to develop this inter-agency linkage, Parent Focus established in January 1977, with the technical assistance of the National Alliance Concerned With School-Age Parents, a city-wide task force representing multi-disciplinary professionals from public and private agencies, parents and youth. The District of Columbia Task Force on Adolescent Sexuality and Parenting is committed to raising the level of community awareness regarding adolescent sexuality and parenting, linking existing health, educational and social services in the community and providing technical assistance at the local level. Separate testimony on S. 2910 has been submitted by the District of Columbia Task Force on Adolescent Sexuality and Parenting.

In light of the critical and immihent health, educational, and economic problems associated with teenage pregnancy and parenting, Parent Focus supports S.2910 for its overall goal in wanting to improve services and service delivery to pregnant adolescents and adolescent parents and their children.

We are concerned, however, with the vague objectives of S.2910, the lack of criteria by which priorities will be developed in meeting the needs of pregnant adolescents and adolescent parents, and the bill's strong emphasis on health services with only secondary priority to education and social services. The assumption that health services alone can reduce the costly risks associated with teenage pregnancy is erroneous. In the District of Columbia where minors are entitled to the full range of reproductive services, where sex education is mandated in the District of Columbia Public Schools curricula, teenage women 10-19 years old account for 25% of all pregnancies. It has been Parent Focus' experience that parenting education, infant care, job counseling and other educational and social services which enable young men and women to finish school and gain employment are often stronger determinants to postponing pregnancy than birth control information and the availability of contraceptives.

We strongly recommend, therefore, that the levels of funding for this legislation be increased in subsequent years. We feel that given the very limited funding S.2910 is requesting, the bill is overly ambitious in addressing primary prevention and treatment programs. While age-appropriate health, educational, and social service needs are very real, it seems unrealistic to expect a $60 million appropriation to respond significantly to all these needs.

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Moreover, while the bill stresses prevention, it makes no provision for the direction of some services to pre-adolescents. Parent Focus' experience in working with adolescents, has been that primary prevention of unintentional pregnancies is predicated on the education and knowledge of the young person prior to and during that stage of development when a young woman is at risk of pregnancy and a young man at risk of becoming a father. Such education should focus on the health, educational, economic, and social responsibilities of parenting.

It is therefore Parent Focus' recommendation that S.2910 focus on the educational, health, and social services to pregnant adolescents and adolescent parents and their children and families.

Parent Focus views S.2910 as a valuable beginning effort to meet the multi-disciplinary needs of this adolescent population. We would like, however, to raise three major concerns we have with the bill in light of our experience in linking community agencies in the delivery of human services, specifically regarding the adolescent population:

1. Item a4 of Section 103 of the bill pre-supposes the existence of adequate educational, health, and social services geared to adolescent parents at the community level. Nothing could be further from the truth. As the National Directory of Services to School-Age Parents compiled by the National Alliance Concerned with School-Age Parents in 1976, indicates, services to this population are scattered, understaffed, underfunded with crisis-oriented, short term goals. Age-appropriate birth control counseling, pre-natal care, medical

care at delivery, pediatric care and parenting programs, which take into account the particular characteristics of an adolescent's physical, psycho-social, and intellectual needs and capabilities, are exceptions. Age-appropriate parenting services incorporating health; educational, and social-services, have yet to be developed. Adolescent medicine is a new word in the health vocabulary, recognition of sexuality as an integral component of human development is a concept formal education and service agencies are struggling to understand and are often unwilling to incorporate in their service delivery philosophy. A case in point is the District of Columbia where with the close of the federally funded Webster School for Girls in 1972, age-appropriate educational, health, and social services regarding adolescent sexuality and parenting, are few indeed, even though the Superintendent of District of Columbia Public Schools mandated in 1973 to the six school regions to provide the support services heretofore made available to Webster. Thus Parent Focus recommends with regard to Item e, Section 102, increasing the proposed 50% level of funding allotted for the delivery of direct services to 75%. Linkage of services cannot be effected where services do not exist. Adolescent services are often most absent in communities with the highest incidence of teenage pregnancy.

2. Parent Focus' second major concern regards Item 6 of Section 102 of the bill which excludes funding support for institutional training or training and assistance provided by consultants. One of Associates for Renewal in Education, Inc.'s major objectives, implemented successfully since 1971, has been staff development for educators, health and social service providers and administrators. Associates for Renewal in Education, Inc. draws on consultants with special expertise from both institutions and community agencies, to design and implement intensive short-term and long range training. Training offered by Associates for Renewal in Education, Inc. earns graduate credit from Trinity College. Associates for Renewal in Education, Inc. has found that institutional credit which necessities approval of the training model and the instructor's expertise by the post-secondary institution is a <u>strong incentive</u> to prospective training participants. Such training provides for quality control, continuity, and a linkage between needs assessment and training programs. We recommend that S.2910 be revised to include institutional training and training provided by consultants with expertise in adolescent health, education, and service delivery.

3. Parent Focus would like to raise issue with Item 6b of Section 102 in that it fails to mention day care and specifically <u>infant care</u> as a service S.2910 is concerned

in providing. It has been Parent Focus' experience in the District of Columbia that the major cause for adolescent mothers dropping out of school is lack of school-based or community-based infant care. Moreover, Parent Focus has witnessed the multiple benefits that the provision of infant care can have in helping adolescent parents cope positively with the responsibility of parenting and grow as individuals and as parents. The development of a comprehensive parenting program in the Parent-Child Center at S.T.A.Y. was a direct outgrowth of the provision of basic child care for infants, toddlers, [redacted] pre-schoolers of students enrolled at S.T.A.Y. If S.2910 is concerned with assisting pregnant adolescents and adolescent parents to become productive and independent contributors to family and community life (Item 1b, Section 102), it is necessarily concerned with the adolescent's completion of education and parenting skills. If the bill is concerned with reducing the high school drop out rate of adolescent parents and improving the quality of their parenting, it must address the provision of school and neighborhood-based infant care. Finally, Parent Focus would like to offer the three following recommendations regarding the REQUIREMENTS FOR GRANT APPROVAL.

1. Item 10 of Section 104 requests a community testimony by public agencies for the need of services. We feel this request defeats the overall purpose of S.2910 in that communities with the greatest need and those who have not developed a statistically reliable profile of that need, would be ineligible. The District of

Columbia is a case in point. Data on reported terminations of pregnancy (live births, abortions, miscarriages) by age and residency have been compiled only since 1975; much of it is still unpublished data. Parent Focus recommends that communities lacking hard reliable statistical data from public agencies be allowed in lieu of the testimony, to develop a statement of need by a community advisory council representing multi-disciplinary public and private agencies, parents and adolescents, and a description of the criteria and procedures by which such a council was recruited.

2. Title II, Item 5c, Section 201 entitles the Secretary to set aside no more than 1% of funds appropriated for evaluation. Parent Focus fells this is an extremely limited allocation. Development of cost effective adolescent health programs must be predicated on a reliable knowledge base of intervention programs. To date that knowledge base has been very thin. Intervention programs have mushroomed across the country with no guidelines or criteria, due in large part to the absence of evaluation of these programs.

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3. Item 11b of Section 104, requests grantees to include in their report, the impact the project has on reducing the rate of first and repeat pregnancies. While Parent Focus supports fully the objective of to reduce the rate of such pregnancies, we question the impact which a project funded for less than 3-5 years, can have on reducing in an accountable manner, such pregnancies, in view of the nine month duration of pregnancy.

Finally, we recommend the establishment of an Advisory Council including representation of service providers to advise HEW and to insure that the $60 million have a maximum impact on the problems associated with adolescent pregnancy and parenting.

In conclusion, Parent Focus of Associates for Renewal in Education, Inc. wishes to reiterate its support of S.2910 , and offers its expertise in providing efforts which address the very complex and multi-disciplinary needs of pregnant adolescent and adolescent parents.

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ASSOCIATES FOR RENEWAL IN EDUCATION, INC.

Statement of Capability

Associates for Renewal in Education, Inc. is a non-profit 501 (c) (301) organization formed in 1971 to improve the quality of education in the District of Columbia Public Schools. Since 1971 ARE has been concerned with the development and implementation of quality action-research and demonstration projects focussed on the improvement of educational services and community involvement in the greater Washington area. Projects in teacher training, parent and community training, communications, research and development of training materials and curriculum, planning and design of educational programs to meet the specific needs of the District of Columbia Public Schools, day care centers, social service organizations, parents, youth and the citizenry at large, have been carried out successfully for both local and national dissemination. ARE also provides evaluation services to local and national community and educational organizations and institutions.

Associates for Renewal in Education occupies a unique position in the Washington Metropolitan area. Although it manifests similarities to other educational institutions, an inherent distinction is its ability to gather the best resources available from local, national and international human service deliverers to mesh the needs assessed to resources. Thus, A.R.E., Inc. is able to maintain the capability of taking advantage of the best of the resource world without being hindered by institutional contractual arrangements and is able to respond through integrated services in an efficient, responsible manner to our clients. In addition to our extensive research capability, we are also able to act as a conduit between those learning needs of the practitioners and the appropriate products of research efforts.

Associates for Renewal in Education, Inc. has served as a barometer for the community in the areas of early childhood education, local history, parent education including school-age parenthood. As such it has spearheaded and supported efforts which upgrade personal growth and development and educational achievement as well as efforts which network the community in problem solving and which stabilize the family by enhancing family cohesion. It has aided in the filtering of different perspectives between administration and staff in the school system, parents and educators, institutions and private organizations, educators and other professionals, youth and adults on such issues as the Black contribution to local and national history, management by objectives, Competency Based Curriculum, the fostering of humanistic education, and individual and family needs in a technological society. As a result, strategies and programs developed, implemented and tested by ARE have been incorporated into the D.C. Public School System in the areas of reading, math, social studies, human gorwth and development, parenting education and management by objectives.

ARE currently operates the following projects:

- THE ADVISORY & LEARNING EXCHANGE, a teacher center, has since 1971, focused on providing teacher training to promote the most creative/positive educational millieu within the schools and community. It has offered workshops and courses as well as individual consultation to teachers, administrators, parents, students, children in art, reading, math, language, social studies, bilingualism, special education, learning disabilities, classroom organization and management and specialized needs.

  It offers courses for undergraduate and graduate credit in educating exceptional children, juvenile justice, use of media in teaching, learning disabilities, diagnostic-prescriptive teaching, learning centers, metric, curriculum development, problem-solving and specialized areas which are an outgrowth of mainstreaming such as working with the handicapped and adolescent parents.

  These workshops and courses are conducted both on-site and at regional and school locations.

- THE DISTRICT OF COLUMBIA HISTORY PROJECT is a response to a mandate of the Board of Education that all students take a course in the history of Washington before they graduate from the District of Columbia Public Schools. The project brings together a team of teachers and scholars to develop the design for a new junior high school social studies curriculum to teach the history of the District of Columbia. The course is a community project, involving teachers, school administrators, historians, students, museum personnel and city officials. It is designed to vitalize the study of history by bringing the subject close to the lives and experiences of the students.

  The project has been in operation for two years with a continuing emphasis on refinement and revision. Curriculum objectives will involve students in researching the history of their own families, neighborhoods and schools; seeking clues to the mysteries of the past through primary sources (e.g., old maps, newspapers, photographs and diaries), and discovering themes from the past which are reflected in issues facing the city today.

  The projected goal is to provide a curriculum for K-12 on the history of the District of Columbia with activities and materials for implementation.

- PARENT FOCUS concerns itself with issues of parenting and family life as they affect parents, school-age parents, school and social service personnel, day care and pre-school staff, young adolescents. The project outreaches to adolescent parents, adolescents at risk of pregnancy and to those professionals who work with high risk families through,

35-454 O - 79 - 48

program design, organizational implementation, training, development of training materials, and conferences. The project makes available to adolescent parents, professionals and teachers information and training on effective parenting skills; conducts courses, workshops, discussion groups and informal sessions to bring together parents and professionals to share ideas and experiences on parenting "to help the parent help the child." Two pilot efforts of Parent Focus involve educators and social service providers in the study of teenage parenting; understanding the scope and levels of decision-making teenagers face in family planning and parenting, and school-age parents in the study of child growth and development. Parent Focus has organized a city-wide task force, The District of Columbia Task Force on Adolescent Sexuality and Parenting, to impact on the problem of adolescent pregnancy and parenting in the city. The Task Force represents professionals from the schools, health and social services. The Task Force is concerned with promoting greater public awareness and stimulating more action on behalf of the public and private sectors in addressing this issue.

- ARTIST-IN-RESIDENCE PROGRAM has focused for the past two years, on the multi-displinary use of music and history to provide a medium of learning for young people and the community. The first year's efforts included the production of Happy Birthday Black America, a musical, composed, written and directed by Grace Bradford to identify and celebrate the contributions of Black Americans to the history of our nation. The musical opened at the Ford Theatre in August, 1977 for four performances, moved to the American Theatre at L'Enfant Plaza and then toured each of the six regions of the D.C. Public Schools. During the performances of the production in the school system, workshops were held with participating teachers of all levels to provide information, skills and activities for use pre- and post-performance with their students. A final production was requested by the D.C. Department of Recreation which was held at the Carter Barron Amphitheatre to open the 1977 Summer in the Parks Season. The cast is currently preparing for a production at Bowie State College as a part of the Homecoming Activities.

  Presently, a new musical effort is underway entitled "This is Washington, D.C." to complement and enhance the efforts of the D.C. History Project and the Young Washingtonians.

- YOUNG WASHINGTONIANS CULTURAL HERITAGE PROJECT (1974-77) brought together public and private school students representing Black, White, Asian and Latin ethnic groups and varying socio-economic backgrounds to research, refine and dessiminate audio-visual and printed materials on the cultural heritage of twelve neighborhoods in the District of Columbia. These students conducted primary research, developed and used oral and traditional research skills, studied and were trained by professional historians and media persons. These young men and women have produced video tapes, slide sequences and walking tours of these neighborhoods. In addition they have neared completion of a narrative and picture story in addition to a number of games to create enthusiasm among elementary and junior high students in the area of local history.

- THREE JUNIOR HIGH SCHOOLS PROJECT was a three year program funded by National Institute of Education to investigate the possibilities of applying Management by Objectives to educational administration and the classroom. Initially the Project worked with three junior high schools during Phases I and II, but during Phase III emphasis was focused on two schools and linkage with junior high schools that had not been involved with the project. The Project Director also initiated and implemented training programs bringing together the concepts of MBO and Competency Based Curriculum objectives. Although the Project will end shortly with the delivery of the final report to NIE, the success of the project has been exemplified through a contract which is being worked out between NIE and DCPS to continue and incorporate the project into the school system through the Division of Instruction. The costs applicable to this project will be shared by the system and NIE.

- CELEBRATION IN LEARNING '76 (1975-77), a research and demonstration project funded by the U.S. Office of Child Development developed training workshops and materials for personnel working in early childhood education which enabled participants to achieve a satisfactory level of performance of competencies specified for the Child Development Associate. These competencies relate to organization of physical space and physical objects in children centers and learning environments. The training sequences for the competencies were developed around the eight physical objects most frequently used by children in centers in the Washington, D.C. area: the house corner, blocks, table toys, the easel and art table, books, water table, clay and play dough and sand. The design for the project involved teachers from private day care - proprietary day care, church groups, city day care and school kindergartens and pre-schools. Manuals were developed for the training of competencies in each of the areas as well as an annotated bibliography on valuable materials for parents, teachers and teacher trainers, children's literature with special emphasis on literature for Black and Hispanic children and non-sexist literature. These materials are being disseminated nationally by the Office of Child Development.

Some specific contracts in which ARE has been involved or has carried out include:

- TEST TAKING SKILLS - Region III, D.C.P.S. - A.R.E. assisted Region III in training self-selected and designated teachers to prepare students for test-taking exercises.

- BIG SISTERS - To train Big Sisters in tutoring and motivational skills in order that they might respond to the needs of their Little Sisters. They will also receive instructions on charting progress and working with the counselors at school.

- PLANNED PARENTHOOD requested the auspices of the Advisory & Learning Exchange to offer a three credit graduate course for D.C. Public School personnel, "New Trends in Sex Education," in the summer and fall of 1977. Two sections were offered this summer which had a waiting list. Numerous requests have resulted it being offered this fall.

- REPORT OF THE UNITED STATES COMMISSION ON CIVIL RIGHTS - We participated in the research, analysis and final report of the Report of the United States Commission on Civil Rights: Desegregating the Louisville-Jefferson County Public Schools: A Crisis in Civic Responsibility.

In carrying out these projects, ARE, Inc. has raised more than $1.5 million to provide specialized support, particularly in the area of statt development, to schools and early childhood centers. Of that amount more than $800,000 has been from private foundation sources.

Some of ARE's past program efforts include:

- "Open Space" training for teachers of Shaw Junior High School (1975).
- "Open Space" training for Orr Elementary School parents (1975).
- "Open Space" training for Johnson Junior High School parents (1976).
- Development of a plan for a day care institute for Washington, D.C. (1971).
- Development and publication of a series of competency-based instructional materials for day care personnel (1974).
- Development of a model for training a teaching team in the Baltimore Public Schools, based on the model developed by the Innovation Team in the D.C. public schools (1972).
- Design of the bilingual program and training for the initial core of bilingual teachers of Spanish in the D.C. public schools.(1972-74).
- An Evaluation of African Heritage Month: An In-School Program of the Museum of African Art

  A.R.E. had the responsibility of evaluating this program which was designed to promote an understanding of African art and culture in six selected District of Columbia public elementary schools with an understanding and use of curriculum materials that relate to the African Heritage of Americans. Areas included in the evaluation were: approach, methods or organization, materials, scope of student, teacher and community involvement, attitudinal changes, and possibilities for incorporating into the existing curriculum of the school system. We also examined the level of retention and attitudinal change in students.

ARE's Advisory and Learning Exchange project operates an educational store, The Teacher's Treasure Trove, where learning materials -- books and kits -- can be purchased. Teachers, parents, and other community people can borrow kits, books, learning materials from the Adivsory's Resource Center.

The Advisory and Learning Exchange publishes a newsletter bi-monthly which

reaches more than 10,000 people. In the newsletter, workshops and courses are announced, books are reviewed, and items of interest to the Washington community, particularly educators, are published.

Associates for Renewal in Education and its six projects are located in a convenient downtown space, and is open to the public from 9 a.m. until 9 in the evening most weekdays, and from 9 a.m. to 1 p.m. on Saturdays. Visitors are welcome to come in and browse in the Resource Center, to make purchases at The Teacher's Treasure Trove.

Since January 1977, Associates for Renewal in Education has established and convened The District of Columbia Task Force on Adolescent Sexuality and Parenting (see attached Profile) .

DISTRICT OF COLUMBIA TASK FORCE ON ADOLESCENT SEXUALITY AND PARENTING

PROFILE

- The District of Columbia Task Force is a community-based effort to link public and private agencies to improve the delivery of health, educational and social services to young adolescents at risk of pregnancy, pregnant teenagers and school-age parents and their children.

- The Task Force members represent the D.C. Department of Human Resources, the D.C. Public Schools, the D.C. Medical Society, Howard University Hospital and Howard University School of Medicine, Sex Education Coalition of Metropolitan Washington, Big Sisters of the Washington Metropolitan Area, the American Red Cross, Family and Child Services, the D.C. Council, the Institute for Urban Affairs and Research, D.C. Commission on the Status of Women, Preterm, the Home and School Institute and the Hillcrest Clinic, as well as parents and youth from the D.C. Public Schools.

- The Task Force is concerned with promoting public awareness and stimulating action regarding adolescent sexuality and parenting on behalf of the community citizenry, professionals and policy makers.

Since January 1977, the Task Force has:

- completed a review of existing policy and policy implementation regarding adolescent sexuality and parenting in the schools, the health services and the social services; of the
- disseminated information on existing resources and their eligibility requirements to school, health and social service administrators;
- implemented an outreach effort in family planning services to young adolescents in recreation centers via a mobile van;
- facilitated the development of programs and services which link public and private agencies in improving service delivery to adolescents.
- testified before the U.S. Senate Human Resources Committee on S. 2910, Adolescent Health, Services, Pregnancy Prevention and Care Act of 1978.

6/26/78

TESTIMONY ON THE ADOLESCENT HEALTH SERVICES AND PREGNANCY PREVENTION AND CARE ACT OF 1978 (S.2910) BEFORE THE SENATE COMMITTEE ON HUMAN RESOURCES

By

SAMUEL R. KNOX, National Program Director

American Social Health Association

I am Samuel R. Knox, National Program Director of the American Social Health Association, a nonprofit national voluntary health organization founded in 1912, and singularly focused on the prevention, control, research and eventual elimination of epidemic venereal disease in the United States.

Through a combined program of intramural and extramural activities, the American Social Health Association directly engages in biomedical research, behavioral research, educational materials development, policy analysis, professional training, the conduct of pilot demonstration projects and public awareness programming, respecting venereal disease.

Throughout the continuous sixty-six year history of the American Social Health Association, the teenager (adolescent, aged 15-19 years) has been prominently featured with regard to all of our research and program efforts. One can hardly contemplate engaging in venereal disease prevention and control without affording special attention to teenagers, in that their role and representation in the nationwide VD epidemic is enormous, as are their needs.

We urge that any legislative initiative or program effort that focuses on the adolescent, particularly the female adolescent and her unique and particular health needs, be they pregnancy prevention and family planning or pregnancy-related services, prominently and equally focus major attention and directly address their related and

inextricably interlocked health needs of venereal disease prevention and venereal disease-related clinical and counseling services. For, to the extent unintended pregnancy is epidemic among female adolescents, venereal disease is pandemic among this group. To the extent adolescent pregnancy represents a health threat to mother and neonate alike, venereal disease represents a mortal threat to mother and neonate alike. As alarming and compelling as the adolescent pregnancy statistics are, the female adolescent venereal disease incidence statistics are far worse — both in terms of sheer magnitude, and also in terms of severity of resulting consequences.

Unintended pregnancy and venereal disease are more than simply correlated phenomena within this subgroup of female adolescents, they are coequal major health issues born of the same set of social, psychological, behavioral, and to an extent, system deficiences. To address one and not the other is ludicrous. To attempt to divorce one from the other is artifical. To opt or consider to do anything other than approach these two major health needs of female adolescents equally and simultaneously is poor public health policy. To the extent that you recognize and acknowledge adolescent pregnancy as a serious problem deserving of your attention, you must now recognize and acknowledge adolescent venereal disease - particularly among females, as a similar, most serious problem, most deserving of your attention.

The unfortunate facts with respect to venereal disease among adolescents between the ages of 15 and 19 are statistically summarized as follows:

Total adolescents (both sexes) aged 15 to 19 years number 21 million. Total female adolescents aged 15 to 19 years number 10.3 million.

Total persons (both sexes) aged 15 to 49 years (interval of peak sexual activity) number 107,819,000.

Total females aged 15 to 49 years (interval of peak sexual activity) number 54,076,000.

Venereal disease incidence among adolescents (both sexes) aged 15 to 19 years is estimated to total over 2,500,000 cases annually.

Venereal disease incidence among female adolescents aged 15 to 19 years is estimated to total over 1,900,000 cases annually.

Venereal disease incidence among females aged 15 to 49 years (interval of peak sexual activity) is estimated to total over 5,000,000 cases annually.

Venereal disease incidence among persons (both sexes) aged 15 to 49 years (interval of peak sexual activity) is estimated to total over 10,000,000 cases annually.

On the basis of the above, the following observations and statistical inferences are made:

- Adolescents (both sexes) aged 15 to 19 years represent 19.48 per cent of all persons aged 15 to 49 years, i. e. one in every 5.13 persons aged 15 to 49 years is an adolescent aged 15 to 19 years.

- Venereal disease incidence among adolescents (both sexes) aged 15 to 19 years represents 25 per cent of venereal disease incidence among all persons aged 15 to 49 years.

- Venereal disease strikes nearly 12 per cent of all adolescents aged 15 to 19 years, i. e. one in every 8.4 adolescents aged 15 to 19 years is stricken with venereal disease.

Regarding Females Specifically

- Female adolescents aged 15 to 19 years represent 19.05 per cent of all females aged 15 to 49 years, i. e. one in every 5.25 females is an adolescent aged 15 to 19 years.

- Venereal disease incidence among female adolescents aged 15 to 19 years represents over 38.0 per cent of venereal disease incidence among females aged 15 to 49 years, i. e. one in every 257 female venereal disease cases is a female adolescent aged 15 to 19 years.

- Venereal disease strikes over 18.5 per cent of female adolescents aged 15 to 19 years, i. e. one in every 5.39 female adolescents aged 15 to 19 years is stricken with venereal disease.

To say that venereal disease reigns as an epidemic among adolescents aged 15 to 19 years is an understatement, and a gross understatement with respect to female adolescents. With case rates of nearly one in five, venereal disease is virtually pandemic within the subpopulation of female adolescents in the United States, and represents one of, if not the principal health threats to female adolescents.

Going beyond the frank and grim reality of this intolerable level of primary venereal disease incidence, one must bear in mind that women and their offspring are the main victims of the consequences of primary venereal disease incidence - the complicated and often irreversible episodes of reproductive (tubal) disfunction resulting from gonococcal and chlamydial pelvic inflammatory disease (P.I.D.) and salpingitis (which themselves are life-threatening infections), the greatly elevated risk of cervical cancer posed by infection with the genital herpesvirus, (HSV-2) (presently there is no cure for genital herpes infection) and repeated infection with the trichomonas vaginalis, congenital infection of the developing fetus with the treponema pallidum, the causative agent of syphilis, neonatal infection of the emerging infant with the genital herpesvirus and the group B streptococcus (both venereally acquired by the mother) and both most often resulting in neonatal death or severe neurological and neurosensory damage to the surviving infants, transplacental infection of the developing fetus with the cytomegalovirus (a sexually transmissible virus) resulting in more infant mental retardation than even the rubella virus.

These harsh facts, unpleasant and tragic as they are, must not be swept under the rug. We must confront these realities. We must seize every opportunity to intervene on these pathological processes. We must candidly acknowledge that these female adolescents, young, inexperienced, unsophisticated, ill-informed, under-informed --- often uninformed, frightened by the prospect of venereal disease vis a vis their peers, parents, and authority figures of various kinds - and often paralysed by such fear --- are ill-equiped to successfully negotiate a medical system oriented toward adults, and hence slip through the cracks far too often and tragically, disproportionately fall victim to the ravages of venereal disease.

Bearing all of this in mind, it is incumbent upon us as humane, foresighted and reasonable people to prominently and forthrightly feature veneral disease as a major policy and program element of any targeted focus on the health services needs of adolescents - particularly female adolescents.

It furthermore makes good sense in all regards to approach the two major health problems facing adolescents women - venereal disease and pregnancy -collectively. First of all, the subpopulations of adolescent women with venereal disease and adolescent women who are, have been or will be pregnant are nearly the same subpopulation. The degree of subpopulation overlap is tremendous. Built upon that perception is the clinical and educational opportunity of mediating both health concerns together --- "piggy-backing" one onto the other, or vice verse, which is of enormous cost effectiveness as well. Also, the dangers venereal disease pose to developing fetuses and emerging infants at parturition render the site and setting for adolescent pre- and perinatal care ideally suited for practicing primary prevention of venerally acquired, maternally imparted neonatal morbidity and mortality factors - with enormous human and economic benefits to all of society.

The Federal government expends nearly half a billion dollars annually on family planning and pregnancy related services -- and yet, despite the efforts supported by this expenditure, an estimated 510,000 unintended adolescent pregnancies occurred. Clearly this target group is being missed -- and any initiatives to focus on this group are just as clearly in order.

By the same token, the Federal government expends $32 million annually for venereal disease prevention and control programs — and yet, despite the efforts supported by this expenditure, female adolescent venereal disease incidence is estimated to total over 1,900,000 cases annually. There too, clearly, this target group is being missed - and any initiatives that would focus on this group are very much in order.

To focus on either major health problem — adolescent pregnancy or adolescent venereal disease (female primarily) — without prominently, forthrightly and simultaneously addressing the other is not sound from a policy viewpoint, health services delivery viewpoint and cost effectiveness viewpoint.

The only reasonable and prudent course of action is to focus attention on this subgroup of adolescent women, recognizing that unintended pregnancy and venereal disease represent their two most important, and woefully underserved health concerns, and address the two with equal candor, dispatch and urgency, and by so doing, in the most cost effective and ultimately beneficial manner.

United States Senate
COMMITTEE ON HUMAN RESOURCES
WASHINGTON, D.C. 20510

June 2, 1978

Mr. LuGene Bray, Jr.
President
Family Planning Council of
Western Pennsylvania, Inc.
Allegheny Tower Penthouse, Suite 1200
625 Stanwix Street
Pittsburgh, Pennsylvania 15222

Dear Mr. Bray:

Thank you for your recent letter requesting that your written testimony be entered into the record of hearings on S. 2910, the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978.

Please be advised that the hearings scheduled for May were cancelled and rescheduled for June 14. I will forward your testimony to Senator Edward M. Kennedy, Chairman of the Subcommittee, with the request that it be entered into the record.

I appreciate your interest in this area.

Sincerely,

Richard S. Schweiker
United States Senator

RSS:dwj

FamilyPlanningCouncil
of Western Pennsylvania, Inc.

LuGene Bray, Jr.
President

Allegheny Tower Penthouse
Suite 1200
625 Stanwix Street
Pittsburgh, Pennsylvania
412 288 2130

May 22, 1978

Senator Richard S. Schweiker
253 Russell Senate Office
Washington, D.C. 20510

Dear Senator:

Enclosed we are sending you our written testimony on Senate Bill S2910, the Adolescent Health Services and Pregnancy Prevention and Care Act of 1978, as proposed by the subcommittee on Health and Scientific Research.

We request that our testimony be entered to the records of the hearings on May 23rd, 1978.

Cordially,

LuGene Bray, Jr.
President

LGB:kls

Resources:
United States Department of Health, Education and Welfare
Pennsylvania Department of Public Welfare
Pennsylvania Department of Health
Client Fees

The Family Planning Council of Western Pennsylvania, Inc. is grateful for the opportunity to respond to the proposed Senate Bill S2910, Adolescent Health Services and Pregnancy Prevention and Care Act of 1978.

As a private, non-profit agency whose primary concern is the well being of people through the provision of family planning, as well as general health care services, we are deeply concerned about the issue of unwanted pregnancies in the adolescent population.

During FY 1977, The Family Planning Council, which manages 47 clinics in 23 Western Pennsylvania counties had a total active caseload of over 67,000 patients, of which over 25,000 or 38% of the total patient population were adolescents during at least one visit to a clinic; almost ½ of all new patients are adolescents who come from both urban and rural areas and are not limited to any one socio-economic subgroup.

Our agency philosophy regarding services to all people, irrespective of their age is as follows:

1. Every person has a right to understand his or her body and it's functions, and the responsibilities and consequences implicit in sexual behavior.
2. People having exercised their own informed judgement are entitled to support services especially when that judgement results in the completion of a pregnancy.
3. Every person has a right to accessible, quality, medical services regarding fertility control.
4. Every person has the right to receive these services in strict confidentiality.

In addition to these principles, we acknowledge the fact that adolescents, because of their physical and emotional immaturity have special needs which should not be ignored.

Hence we agree that a specialised, concerted effort should be made to reach adolescents, both male and female, from all socio-economic backgrounds in order to provide services which will enable them to lead a full life as an adolescent, maturing to healthy adults.

Because of the well documented adverse physical, social and psychological effects on adolescents of pregnancy and child birth, plus the potential hazards of an abortion, in addition to the increased dangen of both physical and emotional disability of infants of teenage parents, the Family Planning Council of Western Pennsylvania, Inc. suggests the following actions in response to the problem of unwanted adolescent pregnancies:

1. Provide comprehensive community education, with an emphasis on behavioral awareness and changing values, geared to parents, educators, medical and social service providers and the media.

2. Provide sex education for children ages 5 through 18 in schools and recreational facilities aimed at giving factual information about sexuality, in order to prevent unwanted pregnancies by lessening need for sexual experimentation.

3. Provide accessible comprehensive health services for adolescents including:
   - General Health Care
   - Family Planning Services
   - Prenatal Care
   - Postnatal Care

4. Provide parenting education plus health and social services to adolescent parents within the school system so as to avoid school dropouts and to improve the quality of life for both the teen parents and their infants.

5. Develop effective birth control methods which fit the health needs and life style of adolescents.

We recognize that for many adolescents, family planning clinics are the entrance point in to the primary health care system, and hence we acknowledge our role in the above mentioned services aimed at preventing unwanted adolescent pregnancies. The Family Planning Council of Western Pennsylvania, Inc. strongly supports the measures as defined in Senate Bill S2910, however; we urge you to put the emphasis in dealing with adolescent pregnancies on prevention through education as indicated in our suggestions.

United States Senate
COMMITTEE ON HUMAN RESOURCES
WASHINGTON, D.C. 20510

May 26, 1978

Mr. Eugene Bray, Jr.
President
Family Planning Council of W.
Pennsylvania, Inc.
625 Stanwix Street
Pittsburgh, Pennsylvania 15222

Dear Mr. Bray:

In response to your request, I have forwarded the telegram text of your testimony to Senator Edward Kennedy, Chairman of the Health Subcommittee with the request it be entered into the record of the hearing regarding teenage pregnancy.

The hearing scheduled for May 23 was postponed until June 14.

I appreciate your thoughtful comments and will keep them in mind as we consider this important issue.

Sincerely,

Richard S. Schweiker
United States Senator

RSS:dwj

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1978 MAY 23 AM 5:38

SENATOR RICHARD S SCHWEIKER
CAPITOL ONE DC 20510

WE REQUEST THAT OUR TESTIMONY BE ENTERED TO THE RECORDS OF THE HEARINGS ON 5-23-78
THE FAMILY PLANNING COUNCIL OF WESTERN PENNSYLVANIA INC. IS GRATEFUL FOR THE OPPORTUNITY TO RESPOND TO THE PROPOSED SENATE BILL S2910, ADOLESCENT HEALTH SERVICES AND PREGNANCY PREVENTION AND CARE ACT OF 1978.

AS A PRIVATE NON-PROFIT AGENCY WHO'S PRIMARY CONCERN IS THE WELL-BEING OF PEOPLE THROUGH THE PROVISION OF FAMILY PLANNING AS WELL AS GENERAL HEALTH CARE SERVICES WE ARE DEEPLY CONCERNED ABOUT THE ISSUE OF UNWANTED PREGNANCIES IN THE ADOLESCENT POPULATION DURING FY 1977, THE FAMILY PLANNING COUNCIL WHICH MANAGES 17 CLINICS IN 23 WESTERN PENNSYLVANIA COUNTIES AT A TOTAL ACTIVE CASE LOAD OF OVER 67,000 PATIENTS AT WHICH OVER 25,000 OR 38 PERCENT OF THE TOTAL PATIENT POPULATION WERE ADOLESCENTS DURING AT LEAST ONE VISIT TO A CLINIC; ALMOST HALF OF ALL NEW PATIENTS ARE ADOLESCENTS WHO COME FROM BOTH URBAN AND RURAL AREAS AND ARE NOT LIMITED TO ANY ONE SOCIO-ECONOMIC SUB GROUP OUR AGENCY PHILOSOPHY REGARDING SERVICES TO ALL PEOPLE IRRESPECTIVE OF THEIR AGE IS AS FOLLOWS 1. EVERY PERSON HAS A RIGHT TO UNDERSTAND HIS OR HER BODY AND ITS FUNCTIONS AND THE RESPONSIBILITIES AND CONSEQUENCES IMPLICIT IN SEXUAL BEHAVIOR 2. PEOPLE HAVING EXERCIZED THEIR OWN INFORMED JUDGEMENT ARE ENTITLED TO SUPPORT SERVICES ESPECIALLY WHEN THAT JUDGEMENT RESULTS IN THE COMPLETION OF A PREGNANCY 3. EVERY PERSON HAS A RIGHT TO ACCESSIBLE QUALITY MEDICAL SERVICES REGARDING FERTILITY CONTROL 4. EVERY PERSON HAS THE RIGHT TO RECEIVE THESE SERVICES IN STRICT CONFIDENTIALITY

IN ADDITION TO THESE PRINCIPLES WE ACKNOWLEDGE THE FACT THAT ADOLESCENTS BECAUSE OF THEIR PHYSICAL AND EMOTIONAL INMATURITY HAVE SPECIAL NEEDS WHICH SHOULD NOT BE IGNORED HENCE WE AGREE THAT A SPECIALIZED CONCERTED EFFORT SHOULD BE MADE TO REACH ADOLESCENTS BOTH MALE AND FEMALE FROM ALL SOCIO-ECONOMIC BACKGROUNDS IN ORDER TO PROVIDE SERVICES WHICH WILL ENABLE THEM TO LEAD A FULL LIFE AS AN ADOLESCENT MATURING TO HEALTHY ADULTS BECAUSE OF THE WELL-DOCUMENTED ADVERSE PHYSICAL SOCIAL AND PHYSCOLOGICAL EFFECTS ON ADOLESCENTS OF PREGNANCY AND CHILD BIRTH, PLUS THE POTENTIAL HAZARDS OF AN ABORTION, IN ADDITION TO THE INCREASED DANGER OF BOTH PHYSICAL AND EMOTIONAL DISABILITY OF INFANTS OF TEENAGE PARENTS, THE FAMILY PLANNING COUNCIL OF WESTERN PENNSYLVANIA, INC. SUGGESTS THE FOLLOWING ACTIONS IN RESPONSE TO THE PROBLEM OF UNWANTED ADOLESCENT PREGNANCIES: 1. PROVIDE COMPREHENSIVE COMMUNITY EDUCATION, WITH AN EMPHASIS ON BEHAVIORAL AWARENESS AND CHANGING VALUES DUE TO PARENTS EDUCATORS MEDICAL AND SOCIAL SERVICE PROVIDERS AND THE MEDIA 2. PROVIDE SEX EDUCATION FOR CHILDREN AGES 5 THROUGH 18 IN SCHOOLS AND RECREATIONAL FACILITIES AIMED AT GIVING

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Western Union Mailgram

FACTUAL INFORMATION ABOUT SEXUALTITY IN ORDER TO PREVENT UNWANTED PREGNANCIES BY LESSENING NEED FOR SEXUAL EXPERIMENTATION 3. PROVIDE ACCESSIBLE COMPREHENSIVE HEALTH SERVICES FOR ADOLESCENTS INCLUDING: GENERAL HEALTH CARE FAMILY PLANNING SERVICES PRE-NATAL CARE POST-NATAL CARE 4. PROVIDE PARENTING EDUCATION PLUS HEALTH AND SOCIAL SERVICES TO ADOLESCENT PARENTS WITHIN THE SCHOOL SYSTEM SO AS TO AVOID SCHOOL DROPOUTS AND TO IMPROVE THE QUALITY OF LIFE FOR BOTH THE TEEN PARENTS AND THEIR INFANTS. 5. DEVELOP EFFECTIVE BIRTH-CONTROL METHODS WHICH FIT THE HEALTH NEEDS AND LIFE STYLE OF ADOLESCENTS WE RECOGNIZE THAT FOR MANY ADOLESCENTS FAMILY PLANNING CLINICS ARE THE EXTRANCE POINT INTO THE PRIMARY HEALTH-CARE SYSTEM AND HENCE WE ACKNOWLEDGE OUR ROLE IN THE ABOVE MENTIONED SERVICES AIMED AT PREVENTING UNWANTED ADOLESCENT PREGNANCIES. THE FAMILY PLANNING COUNCIL OF WESTERN PENNSYLVANIA INC STRONGLY SUPPORTS THE MEASURES AS DEFINED IN SB 82910 HOWEVER WE URGE YOU TO PUT THE EMPHASIS IN DEALING WITH ADOLESCENT PREGNANCIES ON PREVENTION THROUGH EDUCATION AS INDICATED IN OUR SUGGESTION

MR LU GENE BRAY, JR
PRESIDENT

14:00 EST

MGMCOMP MGM

Family Planning Council of W Pa Inc
625 Stanwix St.
Pitt 15222

TESTIMONY OF ASSOCIATION OF LOWER EAST SIDE SETTLEMENTS
c/o UNIVERSITY SETTLEMENT
185 ELDRIDGE STREET
NEW YORK, N. Y. 10002
PHONE: 212 674-9120

IN SUPPORT OF S.2910/H.R. 12146

The Association of Lower East Side Settlements, which has operated a program for low-income teen-age girls for over three years, is grateful for the opportunity to present its views on S.2910/H.R. 12146, the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978.

The Association is composed of six community and neighborhood centers, listed at the end of this testimony, all providing services in New York City's Lower East Side, a multi-ethnic area of 200,000 people, the majority of whom are low-income.

We would like to express our strong support for this legislation. This support is based on our experience in working with the teen-age population at-risk of unwanted pregnancy. Our commitment to the legislation's goals of developing networks of community-based services via better linkages among programs and an increase in the availability of community services stems from our experience in the operation of the DAWN Program (Discovery and Awareness for Women Now) as a joint effort in the six member agencies of the Association. We would like to describe this program, and from that description, it will be clear why we are supportive of S.2910/H.R. 12146.

The DAWN Program, which has thus far been supported entirely by private foundation funds, has, in its provision of services to girls, emphasized several components that the new legislation also emphasizes:

1 - We have developed a coordinated approach among community-based agencies. Six community centers, each serving a different sub-area of the Lower East Side, and thus a slightly different population, have collaborated in developing a comprehensive, but varied, approach to work with minority teen-age girls. The agencies have shared services among themselves, for example, vocational counseling and supplementary educational sctivities, and have served as an access point to additional services that girls need, for example, more intensive help in working out family relationships and health care, including contraceptive information and services where needed. This community network has provided a variety of services that different girls can use in different ways.

2 - We have developed a conceptual approach to providing services to teen-age girls. Our neighborhood, the Lower East Side, ranks third in New York City in teen-age pregnancy, coming after only Central Harlem and East Harlem. It is a neighborhood characterized by poverty, physical blight, high welfare rates, and high rates of health problems. We find a major social characteristic of such a neighborhood to be a pervasive and deep passivity, in particular among the females: life situations "happen" to the girls and young women, rather than their choosing them, and behavior adapts accordingly. Thus, becoming pregnant in one's teen-age years is not something one has necessarily chosen, but is rather the workings of "fate.".

Likewise, dropping out of school is less an active choice than a series of unplanned circumstances that, cumulatively, result in finding oneself out of school. The girls with whom our agencies work see around them passivity, an inability to affect one's life, a sense that one is marginal in every way, and this means that they tend to lack sufficient incentive to anticipate events in life.

It is to this complex of issues that our program has addressed itself: we believe the girls need to acquire skills in anticipating the future, making decisions, exercising control over their lives. Without some vision of this kind and the skills to move towards it, they have little incentive to accept the kind of responsibility for their activities that is necessary for preventing pregnancy. While we support giving out both contraceptive information and devices, we do not think that such an approach is sufficient if one has not involved the girls in a more total approach to their lives.

Thus, our conceptual approach is that to work with these girls, individually and in groups, staff must create programs that emphasize future orientation and development of decision-making skills.

Based on our conceptual approach to girls' needs and our coordinated structure, the DAWN Program has, over its three-year history, emphasized educational and vocational concerns, health and sex education, and leadership development. Activities

in each settlement house/community center have varied, but all have emphssized these foundations. At this point, we believe we have identified some important issues and are moving in the right direction. A research study just being completed, which compares the DAWN girls with a variety of national norms regarding sex knowledge, coital experience, pregnancy rates, drug use, school drop-out rates, etc., indicates that the girls who have been in our program have fared aignificantly better in all these areas.

This brief description of the Association's DAWN Program is intended to provide Committee members with the basis for our comments and recommendations on the S.2910/H.R. 12146. Evidently, we are committed to a community-wide coordinated comprehensive approach to services for teen-age girls as a means of preventing unwanted pregnancies. We recommend that the starting point for services under this legislation be agencies with a holistic approach to the needs of this population, rather than providers of discrete parts, such as just birth control. In other words, the needs of the total girl must be addressed if she is to be helped either to avoid pregnancy, or, if pregnant, to become as self-sufficient as possible. We think that the community centers with a commitment to girls are logical places of access into other services. A network of agencies that covers a neighborhood is an effective way of tailoring programs to reach different sub-populations on the one hand, while being large enough to develop needed linkages with medical facilities, educational

institutions, city wide resources such as employment and vocational opportunities, and statewide resources/efforts to impact on the problem.

In conclusion, we support fully both the intent and the content of the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978. We hope that the legislation will provide for a spectrum of community-based services of varied content, linked together so that teen-age girls can take full advantage of every possible resource.

aless
80 Pitt Street
New York, N.Y. 10002
(212) 674-1740

Member Agencies:
Chinatown Planning Council
Educational Alliance
Grand Street Settlement
Hamilton-Madison House
Henry Street Settlement
University Settlement

Evelyn R. Frankford, Director

Association of Lower East Side Settlements, Inc.

ALESS, The Association of Lower East Side Settlements, was established in 1974 to:

1. Increase coordination of existing settlement service programs.
2. Develop new joint programs in social services, the arts and community development.
3. Coordinate suitable administrative aspects of the member agencies, such as, bookkeeping, joint purchasing, fringe benefits.
4. Serve as a vehicle for joint representation on policy issues, such as, municipal health services, services to the aging and other community concerns.

ALESS program coordination has resulted in the development of:

*** Youth programs
- DAWN Program - Discovery and Awareness for Women Now - a feminist program for 120 low-income minority girls aged 10 to 17.
- A Directory of settlement educational and vocational services.

*** Programs for the Aging
- Home Care Services, funded by the New York City Department for the Aging under Title III of the Older Americans Act.
- A Consumer Discount Program in local supermarkets and small shops.
- Coordination of long-range settlement planning for programs for the elderly.

Other ALESS activities include:

*** Participation in community planning efforts: designated representation on Community Planning Board 3, Health Systems Agency, Inter-Agency Council on the Aging, Lower East Side Neighborhood Coalition.

*** Active support of related community services, e.g. Easyride, a transportation system for the elderly, Police Precinct efforts to protect the elderly from crime.

ALESS members are:

Chinatown Planning Council, 45 East Broadway, N.Y.,N.Y. 10002, 227-9620
Educational Alliance, 197 East Broadway, N.Y., N.Y. 10002, GR5-6200
Grand Street Settlement, 80 Pitt Street, N.Y., N.Y. 10002, 674-1740
Hamilton-Madison House, 50 Madison Street, N.Y., N.Y. 10038, 349-3724
Henry Street Settlement, 265 Henry Street, N.Y., N.Y. 10002, 766-9200
University Settlement, 184 Eldridge Street, N.Y., N.Y. 10002 674-9120

ALESS is an incorporated, tax-exempt social welfare organization. Its Board is composed of the Executive Directors and Board members of the listed settlement houses. It is associated with United Neighborhood Houses of New York, Inc., 101 East 15th Street, New York 10003.

ALESS is supported by the Rockefeller Brothers Fund and the Robert Sterling Clark Foundation. Program support has come from the Vincent Astor Foundation, The New York Community Trust, and the Greater New York Fund Special Allocations Fund.

unh
Affiliated with United Neighborhood Houses

The CHAIRMAN. Thank you ever so much.

[Whereupon, at 5 p.m., the committee was adjourned, subject to the call of the Chair.]